Imperial Care UK Ltd

Holly Lodge Residential Home

Inspection report

208 Maidstone Road
Chatham
Kent
ME4 6HS

Tel: 01634843588

Date of inspection visit:
22 December 2016

Date of publication:
31 January 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on 22 December 2016 and was unannounced.

The home provided residential accommodation and personal care for older people living with dementia. The accommodation was provided for up to 22 people over three floors in the main building and in a ground floor single storey extension. In the main building a stair lift was provided for people to move between floors and an external fire escape had been installed for use in emergencies. There were 20 people living in the home when we inspected.

There was a registered manager employed at the home. 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 home is run. The registered manager was not present during the inspection as they were on maternity leave. However, information we looked at showed how the registered manager led the service and the owners who were the providers of the home assisted with the inspection process.

At the previous inspection on 12 November 2015, we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The two breaches were in relation to the safe management of medicines and the lack of effective systems to assess and monitor the quality and safety of the service provided. The provider sent us an action plan telling us what steps they would be taking to remedy the breaches in Regulations we had identified. At this inspection we checked they had implemented the changes.

At the previous inspection on 12 November 2015 we also made five recommendations to assist the provider to make improvements to the service provided. These recommendations were in relation to how staff were deployed at key times, choices around food, the supervision of staff, suitable activities and the review of policies and procedures.

At this inspection we found that the provider had taken steps to meet the regulations breached at our previous inspection and made changes in response to the recommendations in our inspection report following our inspection of 12 November 2015. However, at this inspection we have made several further recommendations.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The registered manager understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

The provider had updated the medicines policies and a procedures in line with published guidance to ensure the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely.

The provider had reviewed the activities available and continued to introduce a wider range of activities for people both in the home and outside of the home. An activity planner displayed enabled people to see what activities they could participate in.

We observed people had access to a variety of foods and a menu was displayed to enable people to decide what they may like. At lunch time people were given a verbal choice of foods and were shown the foods if needed to assist them to make a decision. People from different cultural backgrounds were provided with food in line with their cultural choices.

The quality audit systems had been reviewed within the home to make them more effective. The risk in the home was assessed and the steps to be taken to minimise them were understood by staff. All of the policies we viewed had been updated to comply with current legislation.

The home was cleaned to a high standard following a cleaning schedule which included a deep cleaning routine; there were no unpleasant odours in the home. The provider had used a recognised contractor to test the homes water systems for potential infections. However we noted that a risk assessment and management plan was not in place covering Legionella. We have made a recommendation about this.

People and their relatives described a home that was welcoming and friendly. Staff were upbeat and happily provided friendly compassionate care and support. People were encouraged to get involved in how their care was planned and delivered. The care planning systems in the home took account of people's independence and rights to make choices. Staff understood how to resect people's privacy and dignity. However, we noted that in one case a member of staff had not considered this when cutting people's nails in the lounge. We have made a recommendation about this.

New staff received an induction and training was on going and planned in advance. New systems had been implemented for supervisions and appraisals. Records showed and staff confirmed the new system was in use.

We observed people who looked relaxed and safe. Relatives told us that their loved ones were well cared for and safe in the home. Staff had received training about protecting people from abuse. Staff understood their responsibilities to protect people from harm. The management team had access to and understood the safeguarding policies of the local authority and followed the safeguarding processes.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working in the home. The provider ensured that they employed enough staff to meet people's assessed needs. Staffing levels were kept under constant review as people's needs changed.

People had access to GPs and their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell and additional care from community nursing teams.

The provider, registered manager and care staff used their experience and knowledge of people's needs to assess how they planned people's care to maintain their safety, health and wellbeing. Risks were assessed and management plans implemented by staff to protect people from harm.

Incidents and accidents were recorded and checked by the registered manager to see what steps could be taken to prevent these happening again.

The provider and management team ensured that they had planned for foreseeable emergencies, so that should they happen people's care needs would continue to be met. The premises and equipment were maintained to keep people safe.

The provider and registered manager had involved people and relatives where appropriate in planning their care by assessing their needs and asking them about their lives and histories. This helped staff deliver care to people as individuals. After people moved into the home they were asked on a regular basis about their experiences of the care they received. Each person had a key worker and we observed that staff knew people well.

The provider and staff understood the challenges people faced from their dementia. They demonstrated a commitment to work with other health and social care professionals and do all they could to work through some of the issues people faced. Staff encouraged and supported people to maintain their health by ensuring people had enough to eat and drink.

If people complained they were listened to. The provider and the registered manager made changes or suggested solutions that people were happy with. The actions taken were fed back to people.

The registered manager and other senior managers provided good leadership. The home was well led by an experienced registered manager. The registered manager had wider management support within the home as the providers were based at the home and supported the registered manager. Staff and relatives told us that managers were approachable and listened to their views.

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 what they should do to identify and raise safeguarding concerns.

There were sufficient staff to meet people's needs. There were safe recruitment procedures.

Medicines were managed and administered safely. Incidents and accidents were recorded and monitored to reduce risk.

The premises and equipment were maintained to protect people from harm and minimise the risk of accidents.

Is the service effective?

Good

The service was effective.

People were cared for by staff who knew their needs well. Staff encouraged people to eat and drink enough.

Staff met with their managers to discuss their work performance. Staff received an induction and on-going training.

The Mental Capacity Act and Deprivation of Liberty Safeguards were followed.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated. People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

Staff protected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on assessments and the development of a care plan about them.

Activities were being developed based on people's needs.

Information about people was updated often and with their involvement. People accessed urgent medical attention or referrals to health care specialists when needed.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Good

The service was well led.

There were clear structures in place to audit, monitor and review the risks that may present themselves as the care was delivered. Actions were taken to keep people safe from harm.

The provider and registered manager promoted person centred values within the home. People were asked their views about the quality of all aspects of the care they received.

Staff were informed and enthusiastic about delivering quality care. They were supported to do this on a day-to-day basis by leaders in the home.

Holly Lodge 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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 22 December 2016 and was unannounced. The inspection was carried out by one inspector.

The provider completed a Provider Information Return (PIR). The PIR 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. We looked at the provider's action plan and previous inspection reports and notifications about important events that had taken place at the home, which the provider is required to tell us about by law.

Not all of the people at Holly Lodge were able to tell us about their experiences. Therefore, we spent time observing the care in communal areas. We observed how staff communicated with people so that we could understand people's experiences.

We spoke with three people and five relatives about their experience of the home. We spoke with six staff including the two owners of the home (the providers), two senior care workers, one care worker and the cook. After the inspection, we received further feedback from relatives using the CQC contact number. We asked for feedback from two health and social care professionals involved in the commissioning of the service.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at five people's care files, six staff record files, the staff training programme, the staff rota and medicine records.

Good

Is the service safe?

Our findings

At our inspection on 12 November 2015, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines had not been managed in line with guidance issued by The National Institute for Health and Care Excellence (NICE). We also made a recommendation about the deployment of staff to meet people's needs.

At this inspection, we found the provider had made improvements by implementing and following a new medicines policy which was based on NICE guidance. The provider had also changed the way staff have been deployed at critical times in the home, early in the morning and at night. For example, there was now an additional member of staff from 07:00 hours.

We saw people smiling when staff spoke with them, we observed that people were relaxed and comfortable with staff when care was delivered. All of the relatives we talked with told us that their loved ones were safe. Relatives said, "We have no concerns about safety, the owners are very approachable" and "This is a safe place."

At the last inspection, we found that the provider had not ensured that certain medicines were recorded appropriately and that the member of staff trained to administer medicines was dispensing medicines for other staff to administer.

At this inspection, we found that staff understood how to keep people safe when administering medicines. The provider's policies set out how medicines should be administered safely by staff. This ensured that medicines were available to administer to people as prescribed and required by their doctor. The registered manager checked and recorded staff competence, they observed staff administering medicines ensuring staff followed the medicines policy. Records showed, and staff confirmed that medicines training and competency checks had taken place. Due to the layout of the home staff administering medicines could not access areas of the home with a medicines trolley. However, we observed staff administering medicines taking medicines to people who were still in their bedrooms in clean pots and then returning to the medicines trolley and signing the medication administration record (MAR). Staff administering medicines knew how to respond when a person did not wish to take their medicine. For example, they would return later. In one instance we observed a member of staff gently discussing the medicines with a person before they agreed to take them.

The MAR sheets showed that people received their medicines at the right times. The system of MAR records allowed for the checking of medicines, which showed that the medicine had been administered and signed for by the staff on shift. Senior care workers checked the medicines administration was correct each day. Medicines were correctly booked in to the home, stored and when required disposed of by staff in line with the homes procedures and policy. Medicines were stored securely at the right temperatures to prevent them from becoming less effective. Medicines systems were regularly audited by the providers. Issues from audits were recorded as were the actions taken to address the issues.

Staffing levels were planned to meet people's needs. The rota showed staff being deployed flexibly and at times, where they were most effective. For example, more staff were available at meal times and when people needed more support with personal care in the morning and late evening. In addition to the registered manager and the two providers there were seven staff available to deliver care during the day. Each daytime shift was led by a senior carer. At night there were two staff and a senior carer delivering care. We observed staff were on hand to provide care and meet people's needs. Staff and relatives told us there were enough staff. Cleaning, maintenance and cooking were carried out by other staff so that staff employed in delivering care were available to people. Staff absences were covered within the existing staff team whenever possible. This ensured that staffing levels were maintained in a consistent way by staff that people were familiar with.

People were protected from the risk of receiving care from unsuitable staff. The registered manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Records confirmed that staff recruitment followed the provider's policy. Staff had been through an interview and selection process. Applicants for jobs had completed application forms and been interviewed for roles within the home. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions, or if they were barred from working with people who needed safeguarding.

The premises were maintained to protect people's safety. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping. A hoist was available for emergencies, for example if people fell and needed help to get up. Other environmental matters were monitored to protect people's health and wellbeing. Firefighting equipment and systems were tested as were hoist, the lift and gas systems, these included an annual legionella water test. The management team kept records of checks they made so that these areas could be audited. We noted that further work was required around the management of legionella risk. For example, a full risk legionella risk assessment and management plan was not in place. This was confirmed by the owner of the home. Not having a management plan in place meant that people may not be fully protected from waterborne viruses.

We have recommended that the owner check their policies against published guidance from the health and safety executive or the department of health in relation to the management of waterborne viruses.

People were protected from harm by staff who were trained and understood how to safeguard people. The provider had policies about safeguarding people and about protecting people from the risk of foreseeable emergencies, such as power failure so that safe care could continue. For example, arrangements were in place for people to be evacuated to safety but their care could continue. The registered manager had an out of hours on call system, which enabled serious incidents affecting people's care to be dealt with at any time.

The provider and registered manager understood how to protect people by reporting concerns they had to the local authority and taking action in protecting people from harm. Staff spoke confidently about their understanding of keeping people safe. They understood the providers safeguarding policy. Staff gave us examples of the tell-tale signs they would look out for that would cause them concern. For example, bruising. Staff understood that they could blow-the-whistle to care managers or others about their concerns if they needed to. We saw records of the investigations, the reporting of concerns to the local authority and actions the registered manager had taken to safeguard people.

People who faced additional risks if they needed to evacuate had an emergency evacuation plan written to

meet their needs. Staff received training in how to respond to emergencies and fire practice drills were in operation. Records of fire drills and test were kept showing these happened on a regular basis.

The risk people faced as individuals and from the environment had been assessed to protect them from harm. As soon as people started to receive care, risk assessments were completed by staff. All of the risk assessments we looked at had been reviewed within the last twelve months. Staff we spoke with were clear about who was responsible for keeping risk assessments up to date.

People had been assessed to see if they were at any risk from falls, or not eating and drinking enough. If they were at risk, the steps staff needed to follow to keep people safe were well documented in people's care plan files.

Incidents and accidents were investigated by the provider and registered manager to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. For example, the registered manager looked out for trends or recurrences of incidents so that appropriate referrals could be made to other health and social care professionals, like the community falls or mental health team. Records we saw demonstrated that the risks to people were re-assessed and recorded after any accidents or incidents.

People were cared for in a safe environment and staff were trained to move people safely. Equipment was serviced and staff were trained how to use it. We observed staff providing safe care if people had difficulty walking. Moving and handling training was completed by staff.

Good

Is the service effective?

Our findings

At our inspection on 12 November 2015, we made two recommendations about the choices people were offered around meals and about how staff were supervised effectively.

At this inspection, we found the provider had made improvements by implementing a new menu, employing a new chef and by reviewing the supervision process.

One person said, "The food is very nice". We observed staff introducing new people to each other at the dining room table. Three people were singing to the background music playing in the dining room. One relative said, "The food has been excellent, they bring round drinks and snacks morning and afternoon, they leave it for mum so she knows where it is, all to hand."

Staff understood people's needs, followed people's care plan and were trained for their roles. Relatives spoke highly of the staff. Relatives told us how well staff met their loved ones needs. One relative said, "The staff cope really well with people's dementia". Another relative told us, "Staff remind dad to use his walking stick." This reduced the risk to him from falls. Another relative said, "The staff care for my wife very well, I am very happy with the care, there is a homely feel here too."

People were protected from poor health through staff ensuring they were eating and drinking enough. People were given choices about the food and we observed people eating and drinking well. There was very little food waste at lunch time, which indicted that people liked the food they had been given. People were offered more food if they wanted it. People could get snack foods and drinks at night and between meals if they were hungry or thirsty. We observed snacks being provided at 10:25 hours, which included biscuits and fresh fruit. Menus were varied and seasonal, they were planned to provide a balanced diet for people. The owners of the home told us that when needed a vegetarian choice was also offered. Records showed people could choose foods that were not on the planned menu or that differed from their original choice. For example, people who chose not to eat their meal were offered something else or if people preferred food that reflected their ethnic background. Staff noted when people were not hungry and food was kept so that it could be offered again later. At lunch time staff were assigned to people to provide one to one support where safety and welfare was prioritised so that good support could be given. This supported people with eating, with staff often cutting up food or assisting people to eat.

People at risk of dehydration or malnutrition were appropriately assessed. People who were at risk of choking had also been assessed. Daily records showed food and fluid intake was monitored and recorded. Care plans included eating and drinking assessments. Care plans detailed people's food preferences and allergies.

We observed staff delivering care and support and they were competent in their roles. Training consistently provided staff with the knowledge and skills to understand people's needs and deliver safe care. Staff told us that the training was well planned and provided them with the skills to do their jobs well. Training records confirmed staff had attended training courses or were booked onto training after these had been identified

as part of staff training and development. This gave staff the opportunity to develop their skills and keep up to date with people's needs through regular meetings with managers.

Training was planned and specialised to enable staff to meet the needs of the people they supported and cared for. Staff received training and an awareness of end of life care, and gained knowledge of other conditions people may have such as diabetes and dementia. Three senior care staff had completed a level two dementia awareness course. This gave them a more in-depth understanding of dementia and enabled them to advise other staff about how to provide help and support to people living with dementia. New staff received inductions which followed nationally recognised standards in social care. For example, the care certificate. The training and induction provided to staff ensured that they were able to deliver care and support to people appropriately.

Staff had received training in relation to caring for people with behaviours that may cause harm to themselves or others so that should any issues arise they could respond appropriately. This would enable them to de-escalate situations when people became agitated or anxious. We observed that staff stayed calm and respectful at all times. Staff understood how to keep people calm, which prevented people becoming agitated and anxious and displaying behaviours that other people may find challenging.

Staff were provided with one to one supervision meetings as well as staff meetings and annual appraisal. These were planned in advance by the registered manager and were fully recorded. A new planner had started in September 2016, we saw that 17 staff had received supervisions. Staff told us that in meetings or at supervisions they could bring up any concerns they had. They said they found supervisions useful and that it helped them improve their performance. Staff and their supervision records, confirmed staff were able to discuss any concerns they had regarding care and welfare issues for people living at the home.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services 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. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. The provider and registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

MCA assessments were in people's care plans demonstrating if they had capacity to make decisions about their everyday care, like taking medicines or receiving assistance with personal hygiene. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. These decisions included do not attempt cardio pulmonary resuscitation (DNACPR) forms, and showed that relevant people, such as social and health care professionals and people's relatives had been involved. Records demonstrated that relatives had been involved in meetings and discussions about how best their loved ones should be cared for.

People's health needs were met and where they required the support of healthcare professionals, this was

provided. People accessed support from the chiropodist, the GP, the community nurse and a community psychiatric nurse. Records showed that people, with consent, had received the flu vaccination and other health checks carried out by community nurses, such as blood pressure checks. This protected people's health and wellbeing.

Good

Is the service caring?

Our findings

People told us Holly Lodge was "Lovely" and people smiled when we asked them if they were comfortable and safe. We observed staff who were friendly and genuinely caring towards people at Holly Lodge. Staff we spoke with had the right attitude to care and were committed to delivering compassionate care. One person who had recently moved into the home said, "The staff are friendly." We heard a person saying to staff they felt cold and staff responded by getting them a cardigan from their room. The person later told us they were now warm.

All of the relative's we spoke with were complimentary about the staff and owners of the home and the service provided. Relatives were made to feel welcome and could sit with people and chat in the lounge, conservatory or a quiet room. They were all pleased with staff and management communication and felt their family members were safe. A relative said, "We visit dad two or three times a week and other members of the family are often here. We are more than pleased with the home, the staff are fantastic. The staff are very caring."

Other comments received were, "The staff are loving and caring towards the residents."; "Staff care for dad well, they have a very caring attitude" and "Staff are always kind, caring and respectful."

We observed that staff were polite and cheerful. Staff took the time to understand how dementia or other conditions affected people. Staff got to know people as individuals, so that people felt comfortable with staff they knew well. Staff were aware of people's preferences when providing care. The records we reviewed contained detailed information about people's likes and dislikes and preferred names. We heard staff addressing people by their preferred names.

Staff spent time talking with people. The providers of the home had created a homely environment for people. People were able to personalise their rooms as they wished. They were able to bring personal items with them. We observed that staff knocked on people's doors before entering to give care. Staff described the steps they took to preserve people's privacy and dignity in the home. People were able to state whether they preferred to be cared for by all male or all female staff and this was recorded in their care plans and respected by staff.

Staff operated a key worker system. This enabled people to build relationships and trust with familiar staff. A key worker was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their care. They took responsibility for ensuring that people for whom they were key worker had up to date care plans and liaised with their families if necessary.

People had choices in relation to their care. Where appropriate, staff encouraged people to do things for themselves and stay independent. This was recorded in people's care plans and staff told us they followed this.

People's privacy and dignity was respected. Staff closed curtains and bedroom doors before giving personal

care to protect people's privacy. Staff we spoke with understood their responsibilities for preserving people's independence, privacy and dignity and could describe the steps they would take to do this. However, we observed a member of staff cutting several people's finger nails in the lounge.

We have recommended that the provider reviews this practice with staff so that it comes into line with their policies about treating people with respect and maintaining their privacy.

The atmosphere in the home was relaxed. There were quiet areas people could go to if they wished to sit away from others. For example, one person had chosen to sit on their own at a table outside the lounge. At lunch time people either chose to eat in the dining room, lounge or in their bedrooms. We observed that staff spoke to people with regularity and people were not left in isolation. Staff acted quickly when people called them. We observed staff speaking with people in a soft tone; they did not try to rush people.

The provider had a policy about record keeping and confidentiality. Staff followed the policy, records about people could only be accessed by authorised staff.

Good

Is the service responsive?

Our findings

At our inspection on 12 November 2015, we made a recommendation about the choices people were offered around activities.

At this inspection, we found the provider had made improvements by implementing a new activities planner which included people going to external activities.

One person said, "I have been here a long time, the care and the home suits me." Two relatives told us they thought there could still be more activities for people.

We discussed activities with the owners of the home. The owners told us they would continue the process of improvement. They told us they had been working to improve the activities, doing more one to one sessions with people and providing more staff so that people could go out to the local café or go out for walks. One member of staff said, "Since the last inspection activities have increased, we show people what activities are on offer, there is more one to one activities, like sensory and music and we take people out more."

Resources were made available to facilitate a range other activities. This promoted an enhanced sense of wellbeing, with staff responding to people's social needs. A pre-organised Christmas party has taken place just prior to our inspection. This was popular and well attended by people and their relatives. Photographs were taken as a permanent reminder for people of the activities they had participated in. Comments in care plans showed this process was on-going to help ensure people received the support they wanted. Family members were kept up to date with any changes to their relative's needs.

Activities included chair exercises, art, reading and skittles. We noted that one person was watching a foreign language television programme that was suited to their cultural needs. People who were partially sighted could access sensory puzzles, and the Kent Association for the Blind had been consulted about the provision of books in braille and audio reading material was provided. These were provided on a loan basis and were renewed on a regular basis. Staff provided one to one chats and sessions like hand massage for people who were cared for in bed. People had access to music and television in their bedrooms.

Newspapers were delivered daily for people to access as well as magazines which were handed out when they were available. These encouraged people to keep up to date with current affairs.

The owners subscribed to the red box service operated by the library which provided periodicals, picture books and reminiscent music of past eras, which people listened to. Volunteers from a local church visited approximately once a month to sing with people and hold services at key times, for example Christmas.

People's needs had been fully assessed and care plans had been developed on an individual basis. Before people moved into the home an assessment of their needs had been completed to confirm that the home was suited to the person's needs. Assessments and care plans were well written, detailed and reflected people's choices. Care planning happened as a priority when someone moved in, so that staff understood

people's care needs. Families were encouraged and participating in assisting staff to meet people's needs. They did this by providing information about people's backgrounds. Likes and dislikes and assisted with the planning of care, especially around foods for people from different cultural backgrounds. For example, at lunch time we observed that people with Chinese and Asian backgrounds were provided with foods that met their cultural needs. We also noted that these foods were served to people in line with their choices. For example, the Indian food was served in separate portions on a specially designed tray. This reflected people's needs and choices.

Staff told us that the new care plans were good and provided them with the information they needed to deliver care. English was not always people's first language and for several people living with dementia they had reverted back to using their first language. Although this presented some challenges for staff we noted that the staff team came from a diverse background too, which enabled members of the team to maintain verbal communication with people and respond to their needs. For example, one member of staff spoke Chinese.

Staff consulted people's care plans and were aware of, and responded to people as individuals. The care plan for each person had been reviewed every six months or as soon as and when people's needs changed. The care plans had been updated to reflect these changes to ensure continuity of their care and support. This had been completed when people's medicines or health had changed. Staff knew about the changes straight away because the management verbally informed them as well as updating the records. The staff then adapted how they supported people to make sure they provided the most appropriate care.

The registered manager and staff worked hard to respond to people's changing needs. As people's dementia worsened, they made changes to keep people comfortable. For example, a person had been moved to a ground floor room as they did not like using the stair lift. Care plans evidenced input in people's care from health and social care professionals such as the falls team, dieticians and physiotherapist. People who needed pressure relieving mattresses accessed these and we saw evidence of input from tissue viability nurses. We checked repositioning records against recommended intervals in peoples care plans and found people with tissue viability issues had been repositioned regularly. This reduced the risk of people developing pressure ulcers.

The provider and registered manager sought advice from health and social care professionals when people's needs changed. Records of multi-disciplinary team input had been documented in care plans for Speech and Language Therapist, Continence Nurses and District Nurses. Medicines were reviewed by people's GP. Staff followed guidance and recommendations made by health and social care professionals. This meant that there was continuity in the way people's health and wellbeing were managed.

The staff and registered manager took account of people's complaints, comments and suggestions. The provider had a policy about how people could complain and an easy to read summary of this was displayed for people to see.

People and their relatives had been asked about their views and experiences of using the home. We found that the registered manager used a range of methods to collect feedback from people. There were residents and relatives meetings at which people had been kept updated about new developments in the home. We also observed that during the inspection the owners of the home made themselves available to relatives and chatted with them over a cup of tea. This reinforced the good feedback we received from relatives about the open and transparent culture within the home.

We found that the results of the surveys/questionnaires were analysed by the provider. Information about

people's comments and opinions of the home, plus the providers responses were made available to people and their relatives. For example, staffing hours had been increased by nine hours a day as a result of feedback from the relative's survey in November 2016. Asking for and responding to feedback kept people involved and up to date with developments and events within the home and showed people could influence decisions the provider had made.

Relatives spoken with said they were happy to raise any concerns. They told us that the owners, management and staff were all very approachable. The management always tried to improve people's experiences of the care by asking for and responding to feedback. Two complaints had been received about the home in 2016. We could see that complaints had been dealt with to people's satisfaction. The registered manager had followed the provider's complaints policy and investigated complaints, recoded responses in writing and kept a log of complaints for audit purposes. People and their relatives could attend meetings in the home where they could talk about any concerns or complaints they had about the care.

Good

Is the service well-led?

Our findings

At our inspection on 12 November 2015, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Audits were not always effective. We also made a recommendation that the homes policies and procedures were relevant to the service provided.

At this inspection, we found the provider had made improvements by implementing effective quality audit systems. They had also reviewed their policies in line with the homes statement of purpose.

At the last inspection, we found that the provider had not ensured that audits were robust and effective. At this inspection, we found that audits within the home were regular, responsive and drove improvement. Management carried out daily health and safety checks which consisted of walks around the home and these were recorded. Fire test and risk assessments were up to date and these were audited and recoded weekly. Cleaning schedules followed good practice guidance providing clear instructions to cleaning staff about how to clean, what to clean and how often cleaning was needed. We saw that cleaning staff recorded that they were meeting the schedule and gave details of what had been cleaned.

Policies for as and when medicines (PRN) were now in place and all policies referred to relevant legislation such as the Health and Social Care Act 2008 Regulations 2014. The content of the homes polices related to the operations of the home and staff had access to the policies.

All people, visitors and staff could read the owners 'Philosophy of Care' and the 'Residents Charter' which were displayed on notice boards. Systems were now in place to gather feedback about the quality of the care provided formally from people, their relatives and health and social care professionals. The results had been collated.

A five star food hygiene rating was displayed in the home. Other environmental matters were monitored to protect people's health and wellbeing. Firefighting equipment and systems were tested by specialist engineers as were hoist and the electrical and gas systems. The records of maintenance checks were audited to ensure actions arising from these would be completed.

The owners of the home were based there and were fully involved in the day-to-day running of the service. When needed they also provided hands on care to people with staff. The owners of the home had responded positively to the findings of our last report and had taken advice from a consultant and implemented the necessary steps to improve the quality of the service they offered.

People benefited from a home which was led by a stable and consistent management team. The owners and managers were well known by people and passionate about delivering good quality care. We observed them being greeted with smiles and they knew the names of people or their relatives when they spoke to them.

The registered manager had been in post as the manager for six years. Supported by the owners of the

home they had continued their professional development and held an enhanced management qualification. The senior care staff were experienced in social care and had worked at the home for many years. Staff we spoke with told us that the registered manager was a good manager.

The management team were committed to making the home a good place for staff to work in and they promoted good communication within the team. They asked staff for feedback through staff satisfaction surveys. Staff told us that good team working was promoted. Staff told us they enjoyed their jobs. New staff told us they were made to feel part of the team from the day they started. The owners of the home arranged staff meetings to enable staff to give their views about how the home was run and make suggestions for improvement. Staff said, "If we need anything the owners supply it for us" and, "Staff had input into the design of the wet rooms in the new annex." Staff felt they were listened to, they were positive about the management team in the home. Staff spoke about the importance of the support they got from senior staff, especially when they needed to respond to incidents in the home. Other staff told us their experiences were similar and they confirmed they attended team meetings. The registered manager ensured that staff received consistent training, supervision and appraisal so that they understood their roles and could gain more skills. This led to the promotion of good working practices within the home.

There were a range of policies and procedures governing how the home needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the home. Staff told us they were aware of the policies.

People were protected from risk within the environment and from faulty equipment. Staff reported maintenance issues promptly and these were recorded. Management ensured that repairs were carried out safely. They had signed off works after these had been completed. Records showed that repairs were carried out as soon after the issues had been reported.

The registered manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The registered manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the home. This ensured that people and staff could raise issues about safety and the right actions would be taken.

The owners of the home were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed. There were systems in place to escalate serious complaints to the highest levels within the organisation so that they were dealt with to people's satisfaction.