Forest Pines Care Limited

Chelmer Valley Care Home

Inspection report

Broomfield Grange, Broomfield Hospital Site
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Essex
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Tel: 01245443680

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 23 of November 2016 and was unannounced.

Chelmer Valley Care Home provides accommodation for up to 140 people who require nursing or personal care. There were 57 people living at the service at the time of our inspection and the service was only occupying two floors of the property. The ground floor was designated for people with nursing needs and the second floor for people who required personal care and did not have nursing needs, but may have dementia.

The provider's registration required them to have a registered manager in post. At the time of the inspection, there was a registered manager in place. 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.

A previous inspection in November 2015, found that the service required improvement and had breached in a number of regulations under the Health and Social Care Act, 2008. During this inspection, we found that significant improvements had been made to the management, running and culture at the home and outstanding breaches had been satisfied.

There were enough staff with the skills, and experience to care for people in a safe way. However, at the time of our visit we found that they were not deployed appropriately to take into account people's level of needs. The management team immediately reviewed this due to our findings and made the necessary changes to rectify this concern.

Whilst people told us that they enjoyed the food at the service and there was plenty of choice, we found that meal times on the nursing floor were not enjoyable due to the level of needs of people and the lack of considered deployment of staff mentioned above.

Staff received quality training, supervision, and support to carry out their role effectively.

The staff and managers at the home demonstrated compassionate and caring responses to people, particularly those who became distressed. We observed good interactions and people were complimentary about the positive culture of the service.

We saw that people were treated with respect and dignity. The management team had made a number of changes to the physical environment and the way they cared for people, so that care was less task orientated and more about that person. This area had been a concern on our previous visit to the service.

Care plans contained relevant information about how to care for people's physical health and the service

had worked innovative ways to develop their relationships with physical and mental health professionals. Activity coordinators ensured that people were involved in meaningful activities, regardless of level of need.

The management team were passionate and committed to continue to improve the service, and had good oversight of the service. We saw that they knew staff and the people at the service very well.

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 safe.

Robust recruitment and induction processes were in place to ensure that staff were safely recruited.

Managers and care staff immediately acted on concerns appropriately to safeguard the needs of people at the service.

However, staff were not always deployed effectively to manage concerns identified in dependency tools.

Is the service effective?

Good

The service was effective.

Staff had good training opportunities and had been equipped with the knowledge and skills to carry out their duties effectively.

There was a range of food choices and freshly prepared meals to cater for all people's preferences and need.

People who lacked capacity to consent to care had appropriate assessments in place to safeguard their rights.

Is the service caring?

Good

The service was caring

We saw numerous caring and compassionate meaningful interactions between staff and people at the service.

Staff and managers knew individuals well, including their preferences and interests and encouraged these.

Staff and managers respected people's privacy and confidentiality.

Is the service responsive?

Good

The service was responsive.

Assessments and support plans focussed on people's physical, social, and mental health needs.

People's concerns and complaints were investigated, and responded to promptly.

Is the service well-led?

Good

The service was well-led.

The management team had made significant improvements to the service people were receiving and had clear plans for continued development and improvement.

People, relatives, and staff told us that managers were approachable and there was an open and transparent culture at the service.

The managers had strengthened specialist training available to staff in innovative ways.

Chelmer Valley Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 23 November 2016 and was unannounced.

The inspection team included one inspector and two Experts 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. The experts by experience during this inspection had experience of dementia and nursing care in residential services.

Before the inspection, we reviewed all the information we had about the service. This included notifications and other information we had requested from the provider. We contacted the local authority and commission teams to gather their views of the service.

We spoke to 10 people using the service, 11 relatives and interviewed 11 care staff at various levels of authority. We observed how staff interacted with people, and reviewed nine care plans; risk assessments and other information held about people at the service and checked care notes to ensure that prescribed care was being given.

We reviewed six staff recruitment files, six people's care plans and risk assessments.

The provider's policy, procedures, and action plan for the future were reviewed to assess their ability to identify and mitigate risks to the service and the care provided.

Requires Improvement

Is the service safe?

Our findings

On the day of our visit, we were informed that there was a full complement of staff on both the nursing and dementia wing. A tool was used to identify people's level of need, and how many staff would be needed to support them safely. Whilst the identified number of staff were deployed, they were not always deployed appropriately and number of people and relatives told us that staffing could be better. For example, observations of mealtimes on the nursing floor demonstrated that there were not enough staff to give people the support, and attention they needed.

The majority of the people we spoke with felt that nursing floor was short of staff. One person said, "We're told there's enough staff but it doesn't always feel that way to me." This was supported by a relative who said, "They're always busy; I can't always find them so I go to [name] Manager or [name] senior nurse who is very nice." She concluded, "At weekends, staff levels are low. I spend most of the day here so that I am available." Similarly, a member of staff stated, "Staffing levels are poor, which makes it difficult to provide good care consistently."

However, one person told us, "Staff come when I need then. There's always two to lift me and they do it gently." A relative told us, "There seems to be enough staff around, and they check on [Name] quite often. I don't worry about [Name] now. They look after her well." We observed that people had buzzers within reach and when these were pressed, staff responded quickly.

The latest review of the staffing tool indicated that on the nursing floor they were operating under the allocated numbers of staff whilst the residential floor had over the numbers of recommended staff. We discussed these observations with the management team who acknowledged that staff could have been deployed more effectively and they made immediate changes to staffing at mealtimes.

Staff we spoke with had a good understanding of safeguarding vulnerable people. The provider ensured that this was part mandatory training and that staff received regular updates. When training information highlighted that some staff had not received this training, the manager was able to demonstrate that this was due to new recruitment and that training had been organised.

There were clear processes in place for staff to report concerns to the managers and we saw evidence of when they had felt able to do so. In these case's we saw that the management team took concerns seriously and carried out investigations to determine risk and whether additional referrals and actions needed to be taken, such as following disciplinary procedures and referring concerns to external safeguarding agencies.

Risk assessments demonstrated that staff had the information available to them to understand what they need to do to keep people safe. When specific risks were identified, the care team put into place measures to minimise these risks. For example, one relative told us that prior to the loved ones placement at the home, they had had a number of falls. The relative told us, "[Name] has a contact mat now and staff come quickly." This was confirmed when the person inadvertently placed their foot on the mat and care staff responded immediately. They added, "I'm confident that [Name] is well looked after when I'm not here."

We observed staff undertaking regular checks on people in their rooms. They spend time talking to them and offering them a drink. Before leaving they asked, "Can we get you anything else." A senior carer confirmed that they undertake hourly checks both day and night and two hourly turns, with four hourly "full care" for a person with a high risk of pressure sores. An agency carer stated that, "Strict fluid intake is recorded. They record output. The pads are weighed and fluid balance titrated." Because of this, we saw that staff were able to respond to any changes in people's physical health needs.

We spoke to staff about individuals at the service and they were able to tell us about people they cared for and how they managed individual risks. For example, people with potential to have behaviours that challenged. Staff told us how they supported people in distress and we saw a number of observations of staff sensitively distracting people. Care plans reflected these interventions and staff demonstrated that they had read them. One senior member of staff told us, "I always make sure staff know their limits, if they feel they can't support someone because of their behaviour then we ensure another member of staff will take over. Communication is the key and understanding that sometimes people may be challenging due to their illness."

Premises and equipment were well maintained, and the environments on both the nursing and residential floor were clean, warm, and inviting. Lounge areas had items that people could pick up and use to help with activity and distraction, such as hand sized sensory mats which people living with dementia could hold, dolls, and other interesting objects for people to pick up. These were appropriately cleaned regularly to ensure that all objects that could be shared and used were kept clean to avoid cross contamination.

For people who required moving and handling equipment due to poor mobility, they had their own handling slings, which were neatly hung in their bedroom areas, and cleaned regularly as required. A member of staff confirmed that there was enough equipment to care safely for the residents. They added, "The management team listen to us when we say if a person needs something such as pressure relieving equipment."

Recruitment of new staff was carried out safely, ensuring that all new staff had appropriate background checks, two references and identity checks. However, information held about people's interviews were limited and did not focus on potential staff values and character. Although, it was clear from speaking to the management team that this process was being reviewed and that during interviews they looked for the right people with the right caring attitude.

On the nursing unit one registered nurse and six carers ran shifts. This meant that the one qualified member of staff had to oversee all the clinical activities needed as well as running the shift. For example, wound care, doctor's rounds, medicine rounds, and clinical review of people that needed it. However, we found that there were systems in place to support them in meeting the needs of people. This included good communication evidenced by white boards in the clinical room detailing who and when people needed dressings changed, communication book and handover sheets that demonstrated when people's needs had been followed up and the availability of the manager during busy periods to offer assistance if needed.

We also saw that managers of the units spent time supporting staff in care activities when they were needed. One carer said of the managers, "They always muck in, they are very helpful."

On the residential floor for people with dementia, shifts were run by a senior carer and care staff. The senior care staff demonstrated good knowledge of how to manage the shift and ensure that people's needs were met. Carers were well trained and sought nursing and clinical advice if the felt it was needed. One person said, "The carers check my blood pressure before getting me up to ensure that I am not dizzy. They make sure I'm safe."

Systems in place to manage people's medicines were safe. Staff knew what action to take if they made an error with administering people's medicines or if they found a medication administering chart (MAR) had not been signed. The managers for each floor undertook regular audits to ensure that people were receiving medication appropriately. Following our inspection, we received a safeguarding alert regarding a member of staff not administrating medication. Staff and managers were able to identify this had happened and took immediate action to ensure that people were safe and that correct medical advice and processes were followed.

Nursing staff were observed carrying of medication rounds. They demonstrated competence in dispensing medications and remained with the people to ensure that the tablets were taken safely. Records showed that medicines in the form of patches were put on alternating parts of the body to ensure effectiveness. One member of staff told us, "I do meds in the mornings and I can take a little longer so that I can talk to everyone."

Good

Is the service effective?

Our findings

In the nursing unit, the senior carer was observed to understand the resident's dietary needs, and directed the two other carers who assisted people with their meals. One carer encouraged one person to eat at her own pace after positioning a plate guard while she fed a second person.

However, all the residents required some degree of support and staff frequently broke off to assist others or to intervene to deal with spillages. The carer later said, "It is very difficult at lunch time when every resident needed some help." Whilst we acknowledge that an activity person was on annual leave and usually supported meal times, there had not been any additional consideration to mitigate the impact of this person's absence and there was insufficient staff available to make the dining experience meaningful.

Within the residential unit, we saw that staff supported people wherever they wanted to eat. For example, one person decided that they wanted their dessert in the lounge. However, some relatives for people who resided on both residential and nursing units told us they came at meals times to visit, because there were not enough staff to meet people's needs at these times. One relative told us, "They could do with more staff at lunch time they are busy. I come to help [relative] eat. I think they could do with more staff in the dining room and if they ate with them it would encourage people to eat."

On the residential floor, we saw some very positive interactions between staff supporting people at the service. For example, we saw on person who was walking with purpose and agitated and who refused to enter into the dining room, staff explained that the person would come when they were ready and through gentle encouragement and distraction, they were able to engage the person with their meal.

We fed concerns around staffing at mealtime to the management team who were considering staggering mealtimes, something the registered manager had previously tried on another unit and that had worked well.
Staff received a good introduction to the service, which ensured that they received all mandatory training and time spent shadowing existing staff before being able to work with people independently.

Observations of staff interacting with people at the service demonstrated that they had the skills to support people in their care. For example, the use of manual handling equipment for people, who needed this support, was carried out in a safe and dignified way. It was evident that staff had been trained to use equipment.

For people who became distressed due to confusion relating to dementia, we observed some excellent interactions and quick distraction techniques that were used to minimise distress. These interactions were person centred and demonstrated that staff knew the people in their care well. For example, we observed staff singing and laughing with people and engaging them with activities they enjoyed.

We saw that when staff did not have the skills they were able to recognise this and access additional help and guidance. One person stated, "I panic when I can't breathe at night, the nurse comes, and when my

breathing got worse they call the on call doctor." A relative told us, that the staff were "very able and skilful, and discreetly delivered care with the minimum of fuss which made [Name] feel safe." Another person at the service said, "We all have different needs and staff are trained to recognise what we want."

Supervision took place at regular intervals every three months with the managers to check competency and make plans for future training needs. We saw that supervision covered many aspects of staff's practice and put into place measures to support staff to improve practice if needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions, and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection, we found that the provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People who could not make decisions for themselves were protected.

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. Staff had a good understanding of Mental Capacity Act (MCA) 2005, and DoLS legislation. Records and discussions with staff showed that they had received training in MCA and DoLS and they understood their responsibilities.

Ensuring consent was part of the culture in the environment. The previous inspection had highlighted that not all staff obtained consent, and reflected on people's individual likes and dislikes. However, during this inspection we found it was routine practice for staff to gain consent.

People were encouraged to get up for lunch and eat in the dining room. We observed that five people ate in the dining room on the nursing unit. During lunch a choice of two meals were offered. People were offered choices of fruit juice during meals, and the senior nurse prepared the thickened fluids for the residents who required them.

Dementia friendly resources and memorabilia were positioned on the entrance to the unit, at the end of corridors and in living areas and we saw that people made use of these. A staffing allocation board let people and relatives know who was on duty and who could help them.

Those living at the home could choose whether to have their bedroom doors open or closed whilst they were in their room. The lounge areas were easily visible so that the nurse at the station could observe people who remained in the lounge. At one stage, a manager sat in the lounge on the dementia unit while staff were attending to residents. Quiet areas could be organised for people visiting. In the entrance to the building was a café style kitchen and seating area for visitors and people at the service to make their own drinks and sit together. This was an inviting and friendly space and we saw people using it during the day.

The service was effective in meeting people's physical needs and helping them to move between services. For example, we saw when people had been admitted from hospital who needed end of life care, that the nursing manager had ensured that all the correct assessments and care plans were in place to support that person and their loved ones.

They kept good communication with the local hospital and health and social care professionals to access care and support needed. We saw that people had appropriate health care assessments carried out as the service referred to specialists for advice, such as speech and language therapists. They also promoted independence. One person told us, "I use a wheelchair but I still need assistance to get around. They don't rush me and let me do what I can. They only help when I need them to."

Good

Is the service caring?

Our findings

We found that staff were caring and considerate on both the nursing and residential floor. This was evidenced by numerous positive observations of staff and people at the service. For example, we saw, on one occasion, a person experienced difficulty accessing the tablets from the medicine pot and became distressed when they fell to the floor. The senior nurse closed the door curtains to preserve their dignity and spoke gently to them while the person took the replacement tablets.

A relative told us about their loved one who had dementia and could at times become agitated and distressed. They told us that staff were not afraid to show positive regard and affection to people who needed it. For example, when the person reached out to hold someone's hand, and seek reassurance. The relative told us, "I see the staff with [Name] and they are good with [Name]. They are kind and they give [Name] a hug which [Name] loves and [name] strokes their faces and they are always kind to [Name]." These expressions of positive regard were common in the observations we saw between people and staff.

Staff knew people really well and how best to alleviate distress. Positive interaction was observed between a care worker and a person who was anxious and reluctant to go to the dining room for lunch. The carer made good eye contact and spoke quietly while she gently stroked the person's arm. The carer spoke about the residents painting, which was displayed on the notice board, and reassured the person stating that there was no reason to be frightened. The person responded to this sensitive approach and became calm, and accompanied the carer to the dining room.

We observed a care worker on the dementia unit return to a person who was distressed and tearful, and said, "I will sit with you for a few minutes," gently holding the persons hand and speaking to them quietly.

A senior carer described the home like a large family and, "The families appreciate that. They're welcome any time." This was supported by a relative who stated; "They said that I'm an important part of the family, and to treat this like my home too." A second relative said, "We've been happy here, I'll be sorry to leave." While another relative said, the attitude of staff is helpful and approachable "It couldn't be better."

Every person at the service had a communication note book inside their bedroom door that people, relatives and staff could leave notes to each other to keep them updated. We saw that many people chose to use these, either to update, or make suggestions to staff how best to support their loved ones. This initiative had worked well and we saw that it was used often by people. This demonstrated a caring approach as people and relatives could discreetly relate their worries and staff would indicate in the book what they had done to resolve any concerns.

Choice was offered by staff in all interactions with people, such as whether they wanted to wear a protective napkin when eating, to the choice of clothes they liked to wear and the activities they liked to do. We also saw that people choice when they wanted to get up and go to bed. The manager told us that previously they found a culture where people had lacked choices and it was evident in care plans, and conversations with people that this had now successfully changed. One person told us, "I get up when I want to and wear what I

like."

An ethos of dignity and respect was very evident on both units as care staff closed doors and posted privacy notices when attending to the residents. Comments from people using the service and their loved ones about staff were that staff were respectful, and preserved people's privacy and dignity. We observed interactions that demonstrated this.

For example, during the inspection a person had become unwell. Staff quickly moved to preserve their dignity whilst also offering reassurance that everything was okay and they would help them. When staff used special hoists to transfer people we saw that they did this respectfully, checking with the person that they were okay, explaining what was happening and offering reassurance, and ensuring that their privacy and dignity were maintained, for example, covering a person's legs with a blanket whilst they were hoisted up.

A caring and supportive approach was given to people and their loved ones. A family who had been bereaved of their loved one had requested that they could hold a wake at the home. Managers and staff supported this to happen. The family brought the food and the cook prepared it. This was a considered and caring approach.

Good

Is the service responsive?

Our findings

Since the last inspection, we found that the service had worked hard to improve person centred care. Care plans were personalised and met the needs and likes of individuals, and care staff and managers knew people at the home very well.

Examples of person centred care included rooms decorated to people's personal tastes, including wallpapering when requested and furniture from people's homes if safe to do so. But in addition to this we saw some thoughtful personalised information to help staff to support people. For example, when a person had experienced hallucinations, staff having the information of how to support them. Care plans included information about people's lives, major life events, likes, dislikes and social interests. These were very detailed. Each person had a one sheet "Pen Profile" a shorter version of the care plan that was quick and easy to use on a day to day basis, particularly for new or agency staff. Although shorter, these contained the most important information about the person so staff could get a feel for their needs.

Care plans contained some good prompts for staff to consider if people were in distress. For example, it asked staff to consider whether a person might be too hot or cold, in pain, lonely or bored. For individuals, care plans identified what made things worse for people, for example, staff to understand that logical reasoning would not work with someone who was very confused and that staff should remain calm and give people time to calm down, if safe to do so. In situations like these, touching (i.e. placing hand on shoulder or trying to comfort) might be perceived as threatening. No two care plans were the same and were tailored to the individual.

It was apparent from care plans, observed interactions and interviews with staff and people at the service, that staff supported people to maintain their independence for as long as possible. For example, carers supported people to mobilise at their own pace and waited patiently while they decided where they would like to sit. Not all people responded positively to offers of assistance and carers were heard to say, "Do you need help." One person requested assistance with their meal, a carer replied kindly, "See how you get on, I'll help if you have problems." However assistance was not necessary.

A senior carer said that they encourage people to make basic choices regarding everyday events. This includes having a bath or shower and what clothes to wear. In the dining room. A care worker was observed prompting a person to drink. The person responded by offering the cup to the carer, who replied, "You taste it and tell me if it's nice."

One person stated, "I think it is lovely here, and I am very free to do as I like, lovely food, everybody is friendly." We found that bedtime routines and morning routines varied, dependant on people's individual preferences. For example, one member of staff explained, "[Name of person] likes to go to bed very early after tea, and is usually awake very early, so often the night staff will help them up. Whereas [name of person] likes to go to bed really late, and always has, so we leave them to lay in the morning and we just check them regularly to make sure they are okay. It's just down to personal preference." One person told us, "I wake at early and go back to bed, till mid-morning. I am a free agent, and the staff are nice and friendly. I

am happy here and go to all the entertainments, and I love the games."

We observed a person walking bare footed on the residential unit, and staff were able to tell us why, and demonstrate that this had been the person's choice and they had considered risk. One relative told us that he was involved with planning their loved one's care and discussed her condition with the doctor. "They inform me of any changes; they even phoned me when I was out of the country."

On the residential floor some people we spoke with lacked capacity to give information to staff that would assist with person centred care , However, we saw that staff regularly communicated with individuals' loved ones in order to personalise care provided. Observations of staff interacting with people demonstrated that staff were thinking about what worked for a person, for example if in distress, and this would be incorporated into the plan of care. The shift leader countersigned all carer staff entries and this gave them good insight into people's changing needs. The individual entries could be more person centred as staff documented the tasks, without documenting how the person was, or what they had been doing. The care notes did not always reflect the good quality observations, care plans, and feedback we received from people.

The relatives we spoke with confirmed that carers were aware of people's individual needs, and numerous examples of good clinical care were observed. Relatives we spoke with told us that they got involved in resident and relative surveys and attended regular relative meetings. We saw minutes of meetings with who had attended, and which demonstrated that issues discussed had been considered and, where possible, acted on.

On the nursing floor people we spoke with told us they had not been involved in planning care. However, we did see evidence that people had been involved in reviews, and when people's needs had changed or they had become unwell, staff were responsive in discussing care options with people and family. One relative said, "Since [Name] has been here [Name] sees the doctor every week and his medication had been reduced. "Look at [Name], they are less anxious and more comfortable, more alert and interested in everything that's going on." The relative added "I would like to be here when the doctor visits so that I can speak to him." A number of relatives we spoke too told us they would like to be present when the doctor visited.

People and relatives were encouraged and enabled to raise concerns. One relative told us how they had been unhappy with the food served to their loved one and had immediately complained to the kitchen staff. They told us, "The chef came and found me and apologised for the food and three weeks later came back and asked about the food and it was good. They told me they were now getting the meat from a proper butchers."

Where possible the environment had been adapted to improve people's activity and living spaces. Best practice had been considered in how to adapt the environment and make it dementia friendly. People at the service could enjoy weekly outings to the local pub for a meal. Those less able also received group and individual input from activity staff, who were separate from the care staff and could focus solely on activities.

There had been effort to make the environments accessible and friendly for people with dementia. For example, breaking up long corridor's with interesting spaces for people to engage in. At the end of one corridor, there was a coat stand with lots of bags for people to pick up and carry around. In another area there was an area decorated to look like a beach with a comfortable seating area. A special reminiscence room had been created and people used all these spaces well. These small changes to the environment

provided people with comfort. Managers tried to access local support to help with activities and once a week. A local charity came to the home a few days a week and set up a sweet shop. People were able to buy sweets with monopoly money.

However, for those people who spent most their time in their bedroom, we observed less interaction other than to meet physical needs. One visitor said that people were "left alone for too long and would benefit form a more structured day." When asked whether staff had time to talk to them, one person said, "Not so often, they're so busy." This was supported by another person who said that she wanted someone to speak with. However, we did observe that all people in their bedrooms had access to buzzers and when these were pressed, we saw that people were responded to quickly. This was mirrored in what people told us and one person said, "They come quickly when I buzz for them. They are very good."

Concerns were taken seriously and we saw evidence where people's individual concerns had been managed appropriately. One relative told us they had made a complaint that their loved one was receiving care from male carers when they had requested a female carer. This was immediately rectified. The relative told us, "In the last seven months we have had no male carers we are quite pleased." In addition to this people had complained about the lack of entertainment and activity. They said, "Entertainment has improved and now there is more on and every Thursday they have a concert downstairs. It is brilliant and we get up and dance and join in."

Good

Is the service well-led?

Our findings

We found that there was a strong and open culture at this service, where staff could question practice, express their views and, if needed, use the whistleblowing processes open to them. We reviewed situations where staff had raised concerns and saw that managers followed the provider's policies, supported staff to speak up, and when issues were substantiated, quickly moved to minimise risk and ensure that good practice followed.

Interviews with staff supported our findings. One member of staff said, "Management like high standards and we are encouraged to keep high standards. They want things done properly not quickly," another said, "I am supported, and I can ask management when I need to. I don't need to wait for supervision"

The managers who had been in place during the last inspection, had been sent to make improvements at the service and had demonstrated strong leadership in getting this done. One of these managers had recently been made permanent registered manager at the home, and another person who was yet to start, had been appointed to take over from the interim manager who was in charge of the residential floor.

People, relatives, and staff told us that managers were visible and approachable. One person said, "I speak to the peripatetic manager quite often. They are very pleasant I have no concerns. A relative said, "Any concerns I would speak to [manager on dementia unit] I spoke to her when I came in today and asked for curtains." Within two hours these were being hung by housekeeper." She added that she has not attended relatives meetings, "but will attend" and "Nothing does worry me now here. I can take a day off. If I have something on my mind, I can just say it."

Another relative said, "The managers are down to earth and gets things done." One carer said that much had changed at the care home since the last inspection, "Things are more organised." This was supported by another carer who confirmed that the senior team were very positive and approachable. While another said, "Everything's fine as long as we do the job."

Senior care staff, nursing staff and managers demonstrated positive values respecting people living there and acted as role models. On senior member of staff told us, "We remind staff that people need a little nudge and the opportunity to do things for themselves, and if not they lose the ability and the independence." Another said, "We promote independence, give people choice in their everyday living, what time they get up, what to wear, what to eat, and where they go. For example, if people are awake they are asked do you want to get up we don't wake them up.

We noted that at various points in the day, managers walked around checking that people and staff were okay. We observed occasions when they would sit in communal areas and speak to people so that care staff could be freed up to do something else, like paper work or supporting an individual in need. In addition, there were other occasions when managers were seen visiting people in their bedrooms. We spoke to staff and people at the service and they told us that this was usual practice. This was also evident in both managers' very knowledgeable responses about and towards people at the service. Consequently, we saw

that they role modelled quality interactions with people.

Managers knew their staff well and the culture at the home was good. One member of staff told us, "Staff morale is better, staff are smiling and we are the gate way to management. We get support both ways up and down." In addition to senior managers, carers told us that those carers and nurses running shifts on units were also supportive. We saw that shift leaders were approachable and helpful, offered support when needed and in return expected that carer staff behaved appropriately. On senior member of staff said, "I support the staff, but I will tell them if something is not done right and I always thank them at the end of their shift."

The service submitted appropriate notification's in line with the expectations under their regulatory duties. They also had a positive practice of alerting CQC and local authorities if they were concerned about the welfare of people. For example, if a person was admitted with pressure ulcers. Some notifications did not contain sufficient detail of information, however. Although when additional information was requested, we could see that appropriate risk assessments and investigations were carried out following incidents in order to support individual people, mitigate future risk and drive up quality standards.

Robust quality monitoring systems were in place, and we noted that all quality audits carried out by the managers were up to date and actions were taken when they were needed. The area manager also had a very good understanding of how the service was being run, problems it faced, and was actively involved with managers and staff to meet the organisation targets in quality monitoring. Audits included environmental, infection control, medicine audits, care plan and risk assessment audits, as well as a review of care note entries. Consequently, managers had very good oversight of both units' needs.

Innovative thinking by the management team had also considered how best to engage the local hospital, which the home was situated next to. They had made efforts to build up positive relationships with the local hospital, offering free training space at the home in return for training opportunities for staff. At the time of inspection, these opportunities had lessened, however managers were keen to keep this option open to the hospital.