Avery Homes Kirkstall Limited

Aire View

Inspection report

29 Broad Lane
Kirkstall
Leeds
West Yorkshire
LS5 3ED

Tel: 01133885440
Website: www.averyhealthcare.co.uk/care-homes/west-yorkshire/leeds/aire-view

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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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 27 February and 6 March 2017 and was unannounced. We carried out an inspection in September 2015, where we found the provider was meeting all the regulations we inspected.

Aire View Care Home is located in the heart of a busy local community and overlooks the river Aire. It is convenient for local shops that include a supermarket close by. The home consists of an 84 bed facility across three floors providing residential care and care for some people living with Dementia. All rooms have en-suite shower facilities. There are several lounges, dining and quiet areas. All floors are connected by a passenger lift.

At the time of this inspection 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 who used the service told us they felt safe with the care they were provided with. We found there were appropriate systems in place to protect people from risk of harm. Overall, safe systems were in place to manage medicines so people received their medicines as prescribed. There were enough staff on duty to make sure people's care needs were met. Recruitment processes were robust and thorough checks were completed. The home had enough suitably trained staff to care for people safely. Staff received regular support and supervision.

We found people had access to healthcare services to make sure their health care needs were met. People's needs were fully met with regard to the provision of food and drink. The care plans we looked at contained appropriate mental capacity assessments. We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People told us they liked the staff and found them kind and caring. We saw staff had a good rapport with people, whilst in the main treating them with dignity and respect. There was opportunity for people to be involved in a range of activities within the home or the local community.

Care plans contained detailed, person centred information to guide staff on the care and support required and contained information relating to what was important to the person. These were reviewed regularly and showed involvement of people who used the service or their relatives. However, the information was at times generalised.

People had opportunity to comment on the quality of service and influence service delivery. Quality assurance systems were in place which ensured people received safe, quality care, however, the recording of when actions had been completed needed strengthening. Further development of some documentation was also required, which included people's personal evacuation plans and 'as and when' required

medication guidance. Complaints were welcomed and were investigated and responded to appropriately.

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.

People told us they felt safe. Individual risks had been assessed and identified as part of the support and care planning process.

Overall, medication practice was safe and people received their medication as prescribed.

There were enough staff to meet people's needs. The provider had effective recruitment procedures in place.

Is the service effective?

Good

The service was effective in meeting people's needs.

People received support from staff who attended regular supervision and training.

Staff we spoke with could tell us how they supported people to make decisions. Care plans we looked at contained appropriate mental capacity assessments. Deprivation of Liberty Safeguards applications were made appropriately.

People had access to healthcare services when required and their nutritional needs were met.

Is the service caring?

Good

The service was caring.

Staff had developed good relationships with the people who used the service and knew how to meet their individual needs.

Staff were confident people received good care and their independence was encouraged and in the main, staff understood how to treat people with dignity and respect

Is the service responsive?

Good

The service was responsive to people needs.

People's care plans contained sufficient and relevant information to provide consistent, person centred care and support, however were generalised at times.

People enjoyed a range of activities and were supported to participate in their local community.

Effective systems were in place to respond to any complaints raised.

Is the service well-led?

Requires Improvement

The service was well-led.

People who used the service and relatives were asked to comment on the quality of care and support through surveys and meetings.

Staff felt well supported by a management team who were open and approachable and mostly listened to.

The provider had systems in place to monitor the quality of the service; however, further development and strengthening of some documentation was required to make sure this was fully effective.

Aire View

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 27 February and 6 March 2017 and was unannounced. On the first day of our inspection the team consisted of four adult social care inspectors and two experts by experience. On the second day of our inspection the team consisted of two adult social care inspectors. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the two days of our inspection there were 81 people living at Aire View. We spoke with 13 people who used the service, 11 relatives, two visitors, 15 members of staff, deputy manager and registered manager. We spent some time looking at documents and records that related to people's care and support and the management of the service. We looked at 10 people's care plans and 11 people's medication administration records.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed all the information we held about the service. This included any statutory notifications that had been sent to us. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Good

Is the service safe?

Our findings

At the last inspection we rated this domain as requires improvement. People were not always protected against the risks associated with medicines. At this inspection we checked and found improvements had been made, sufficient to meet regulations around medicines.

People we spoke with told us they always got pain relief when wanted. Comments included, "Yes they are very good" and "I suppose so I have not had to ask." One relative said, "[Name of person] likes paracetamol when required. As they can't swallow tablets easily we asked the Doctor to prescribe it in liquid form this now has been done."

We looked at medication storage. We found the storage cupboards were secure, clean and well organised. Medicine fridge temperatures were taken daily and recorded. Clinical rooms were locked when not in use. We noted the medication fridge temperatures had sometimes gone above the recommended safe temperature. A staff member informed us they always asked maintenance to check the fridges when they found this. However, the record did not show this action. The deputy manager agreed to ensure this was introduced.

Controlled drugs (medicines liable to misuse) were locked securely in a metal cupboard and the controlled drugs register was completed and correct. The register for these medicines always contained two staff signatures for each administration. We saw the log was checked weekly to ensure controlled drugs were managed safely.

There were systems in place to ensure medication for return to the pharmacy was managed safely and properly accounted for.

We observed administration of some medicines and saw medication was given out at key times in a timely way and the process was explained to people and they were appropriately encouraged to take it; this was done in a calm and caring way. We saw medication records gave detailed guidance on the way people liked to take their medication. The information was person centred and clear. For example, one person's records stated, 'Place in hands, give two tablets at a time with a cold glass of juice.'

We saw all medicines were consistently and accurately recorded on medication administration records (MARs). The MARs contained an up-to-date picture of the person and details of any allergies. We looked at people's MARs and found they were fully completed to confirm people had received their medicines as prescribed. However, we found when paracetamol was prescribed as a regular medicine the actual time of administration was not documented. It is crucial paracetamol is not given less than four hours apart. Two staff members told us they ensured the correct time interval as they remembered what time they had administered the previous dose and staggered their medication rounds to reflect this. The deputy manager agreed to introduce the practice of making sure the time of administration was introduced and documented on the MAR.

On one floor we noted occasional gaps in the recording on the MAR, but found stock balances indicated people had received their medication. The registered provider carried out daily checks, although where gaps had already been identified, the details of who this may have affected were not recorded and the action taken in response was also not stated. In the October 2016 meeting for senior carers and team leaders the following was recorded 'Please ensure that you check your MAR sheets after completion of a medication round – this reduces missing signatures'. One staff member said missed signatures on MARs had reduced since the meeting in October 2016. They told us the form didn't help them to record specific details concerning each incident. They said, "I think it's just a statistical thing." The registered manager said these forms were issued by the registered provider, but said they would look to add additional documentation to enable staff to record more detail.

Some people were prescribed pain relief patches. Staff responsible for administration were aware of the need to rotate the position of pain relief patches to reduce the risk of skin damage. Body maps were in place to demonstrate the patches were rotated to different parts of the body.

Some people were prescribed medication to be given 'when required' or 'as directed'. We saw there were some protocols in place giving guidance for staff and indicating the reason the medication was given and why. However, when a medication was prescribed as a variable dose, for example one or two tablets; the protocols did not give the circumstances of when one or two would be required. A staff member told us they always commenced with offering one pain killer to see if this had the desired effect for the person. This was not documented in the protocol. We asked another staff member about one person who did not have a PRN protocol and they told us, "[Name of person] would not necessarily be able to tell us when she is in pain." At the end of day one of our inspection, a member of staff showed us a completed PRN protocol for this person. The deputy manager agreed to make sure all protocols were updated to include full instructions on medicines prescribed with a variable dose.

Staff told us their training on medication was thorough and their competency was checked each year. The provider stated in the PIR 'Medication is audited and errors reported via the significant event process and senior staff complete medication competencies and accredited medication training'.

People who used the service told us they felt safe. One person said, "I'm quite content and feel safe here. I had a sickness bug and they looked after me really well. I've nothing to complain about." Other comments included, "I like the fact that you're safe here. If I ring my buzzer someone comes. If I fall they follow the correct procedure", "Yes it is very comfortable I haven't been in a situation where I haven't felt safe" and "Staff look after me I would pull the cord for the buzzer."

Relatives we spoke with told us they were satisfied with the safety of their family member and felt secure about their care. One relative said, "I have never heard any aggression, she is safe." Other comments included, "I do feel she's generally safe here. She had a fall and they rang me straight away. They always contact me if they think there's anything that I should know", "There is someone here twenty four hours a day to see to her and there is a buzzer in her room", "Mum has a problem with being in the dark I feel that she is safe because she has company all the time" and "At home [name of person] was a wanderer in the early hours of the mornings and she would accidently burn her clothes on the fire, she wasn't safe at home, she is here, there are people to watch her."

One relative told us she wasn't sure whether her relative was safe. "I have always worried that [name of person] might fall if she was left to walk with her walking frame on her own." Another relative told us they were happy overall with their family member's care but felt they needed to check they were ok, for their own piece of mind, when they visited. They commented their family member had been fine.

Staff we spoke with told us people who lived in the home were safe and protected from harm. Staff had received safeguarding training and could describe different forms of abuse which they said they would report. They felt the management team would treat their concerns seriously and take appropriate action. The training records we saw confirmed most staff had received safeguarding training. Staff were also familiar with the registered provider's 'whistleblowing' policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work.

We saw information on display concerning fire alarm tests which were carried out every Thursday. The records we looked at confirmed this happened on a weekly basis and we saw different test points were checked each time. The fire alarm had been sounded in response to unplanned events in July and December 2016 and we saw evidence of fire drills during 2016. Further weekly checks of the fire extinguishers, fire blankets and fire exits had all been completed.

We observed safe moving and handling practice which supported people's dignity and comfort. Risks to people who used the service were appropriately assessed, managed and reviewed through the care planning process. These included risks of falls, pressure ulcers and malnutrition. We saw one person had fallen five times in February 2017 and we saw incident reports for these events. However, this information had not been transferred to their falls diary. We spoke with staff about two people who were at risk of falls and found assistive technology had been arranged for these people as bed and door sensors were in place.

We observed one person being pushed in a wheelchair by a member of staff and saw there were no footplates in place. This meant the person was at risk of injury. We looked at their care plan and saw a risk assessment was in place to cover this which stated this was the person's choice not to have footplates and they had the capacity to make this decision.

We saw people had personal emergency evacuation plans so staff were aware of the level of support people living at the home required should the building need to be evacuated in an emergency. Although these needed some further work to make sure appropriate support levels were recorded and staff understood people's needs. We saw equipment had been regularly tested and all the certificates we saw were in date. Risk assessments were in place for specific areas of the home which included kitchen and laundry areas.

We asked the registered manager how they decided on staffing levels. They told us this depended on the numbers and dependency of the people living at the home at any time. However, they did not currently use a dependency tool to assess the needs of people. They told us they would look at the use of a dependency tool for future staff allocation and deployment. The provider stated in the PIR 'Staffing levels are assessed in line with dependency. Weekly hours are analysed against appropriate staffing'.

People we spoke with told us they thought there were enough staff to meet their needs. Comments included "You're safe in here. There is plenty of staff", "I think so they are always around" and "They are available most of the time. In the evenings they are always around. You can always find one."

We found staffing levels were sufficient to meet the needs of people who used the service. However, we received mixed views from family member's about the levels of staffing in the home. Comments included, "Generally there is enough staff", "She hasn't got many needs apart from washing and dressing when she needs support she gets it", "There always seems to be enough about when we visit", "Not all the time, when [name of person] fell there wasn't enough staff on that day. I am fed up of having to look for staff when people are on the floor" and "No I don't. I don't think its only [name of person] needs, I think there isn't enough for everyone."

Staff told us there were enough staff on duty to meet people's needs. One staff member who commented on staffing levels said, "It's manageable." Another two staff we spoke with said there were enough staff on shift when five staff were on duty but not if this dropped to four. A third member of staff felt four staff was sufficient.

A health professional who we asked about staffing presence in the home said, "I haven't really had to wait for long."

We reviewed the recruitment process to ensure appropriate checks had been made to establish the suitability of each candidate. We found recruitment practices were safe and the service had clear policies and procedures to follow. We saw relevant checks had been completed, which included a disclosure and barring service check (DBS). The DBS is a national agency that holds information about criminal records. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.

Most people who used the service and relatives told us they were happy with the rooms and thought the home was clean. Comments included, "All lovely", "No smells" and "Yes and no." Two relative's told us they didn't think their relative's room was as clean as it could be.

Good

Is the service effective?

Our findings

At the last inspection we rated this domain as requires improvement. Mental capacity assessments (MCA) had not been completed appropriately and the service had made Deprivation of Liberty Safeguards (DoLS) applications without assessing people's mental capacity. At this inspection we checked and found improvements had been made, sufficient to meet regulations around MCA and DoLS.

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 application 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. We saw appropriate DoLS applications had been made for people the service had identified were likely to have their liberty deprived.

We saw the additional care plan dated December 2016 for one person, which said they may try door handles and ask to go home. The 'goal/outcome' recorded stated 'to legally maintain [name of person's] safety in the least restrictive way by not allowing her to leave'. We saw a DoLS authorisation was in place for this person. We looked at the records concerning DoLS for people living at this service and found these were appropriately managed. Where authorisations were coming to an end, a fresh application had been submitted to the local authority. This meant the registered provider was legally depriving people of their liberty in line with the MCA.

The registered provider had taken steps to strengthen records concerning people's mental capacity. Care plans contained assessments of people's capacity to make decisions and were supported by best interest decision records. When people were assessed as not having the capacity to make a decision, a best interest decision was made, involving people who knew the person well and other professionals, when relevant. We saw there was sufficient guidance for staff to follow. For example, a care plan for one person's eating stated 'Asked closed questions to enable [name of person] to weigh up information'.

We asked staff about the MCA. They were able to give us an overview of its meaning and could talk about how they assisted and encouraged people to make choices and decisions to enhance their capacity. One staff member said, "It's important to give people time, go at their pace and check out people's understanding properly." Another staff member said they would offer people choice around whether they wanted a bath or shower, what they wanted to wear and eat and where they might want to go out. They told us, "They're given a nice variety of choice."

Although staff were familiar with the MCA, we found some staff were less sure about DoLS and who these

affected, however, they said they would check with a senior staff member. One member of staff told us everyone on the first floor was subject to DoLS. Another member of staff was not aware whether anyone was subject to a DoLS and a third member of staff believed only one person was subject to a DoLS. We saw from the training records all staff had completed MCA and DoLS training with further staff training arranged for 2017. The registered manager told us they would carry out further refresher sessions on DoLS for staff.

We looked at staff training records which showed staff had completed a range of training sessions. These included health and safety, infection control, food hygiene and moving and handling. We saw there was a mechanism for monitoring completed training and and what still needed to be completed by members of staff. The registered manager told us, there were gaps in some staff members training but this had been addressed. We saw a training programme was in place for 2017, which showed when each training course was due to be delivered. For example, Dementia awareness, behaviours that challenge and communication and customer service had been arranged for April 2017.

Staff told us they were alerted by notices in the staff rooms when they were due to attend training. We asked staff whether their understanding was checked at the end of training sessions. One staff member told us, "A lot of them do have questionnaires at the end." Staff said they received the training they needed to carry out their role. One staff member said they had not received training on mental health issues, yet were supporting a person who had a mental health diagnosis. The registered manager told us mental health awareness training was planned for the coming year.

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. Staff told us they felt well supported and had regular supervision with the manager or deputy manager. They said they received an annual appraisal. One staff member told us, "If we've got any problems we can air it out." We looked in staff files and saw evidence staff had received supervision along with group supervisions, specific topic supervision and staff meetings. The registered manager told us they were looking at making the supervisions more person centred for 2017. We saw staff had received an annual appraisal.

Staff completed an induction programme shortly after commencing their employment. We asked one staff member about their induction and they told us they had received a programme of training as well as the opportunity to shadow other members of the team over two weeks. They said, "It was intense, but I enjoyed it." Two recently recruited staff members also confirmed they had received induction training and had shadowed more experienced members of staff prior to delivering care.

The provider stated in the PIR, 'A three day training programme is delivered, shadow shifts worked until the staff member is competent. Staff receive regular supervision and performance is assessed on an on-going basis'.

We observed lunch and tea time meals. The dining rooms were light and airy, with attractively set tables. People were sat in small groups to encourage conversation and interaction with each other over the meal. Staff provided the support people needed such as making sure people were sat comfortably and had what they needed such as a soft drink or a glass of wine. We saw clear examples of how staff encouraged people to eat. For example, showing people the options and letting them try the options. There was plenty of staff interaction; checking if people were satisfied with their meal and whether they had enough to eat.

People who used the service and most relatives told us they liked the meals and they described them as 'tasty' and 'plentiful'. One person requested a small portion and this was provided. Another person said, "You could be getting extra weight if you carry on." Other comments included, "I am happy that she is

encouraged to eat", "The food is fabulous", "She has never complained about the food she would if she didn't like it", "Yes it's very good", "I have always been satisfied with the food", "I'm not a fussy eater the food is good" and "The food is good she likes her pudding she has put weight on." One relative commented, "They keep bringing her porridge, even though she only wants bread and jam. It just gets left and wasted. I don't think she's properly encouraged or given food that'll tempt her."

We noted the menu stated one option for dessert was cherry pie. We saw four people were clearly disappointed there had been a mistake with the menus and instead of cherry pie they were offered a cold sponge pudding. One person commented: "We have the sponge every other day." Another person said, "The food's okay, but nothing special, gets repeated a lot and you can't take much notice of the menus." We saw mostly positive comments from people who used the service about the food were recorded in the kitchen comment books.

People who were assessed as being at risk of malnutrition were supported by regular weight monitoring, the completion and monitoring of food and drink charts, additional supplements and referrals to dieticians or GP's for any unexplained weight loss. We saw one person's care plan stated they should be weighed weekly and their daily food and drink intake should be recorded.

We looked at the care plan for one person which stated they needed fruit based smoothies and soups. We spoke with staff in the kitchen who told us this happened, although kitchen records concerning people's dietary requirements required some improvement. For example, the same person's supplements were not recorded on this record and another person who needed a fork mashable diet was not recorded as needing a textured diet. However, the chef told us they were aware of people's dietary requirements.

People's wellbeing was supported through regular contact with health professionals. Records we looked at showed a range of healthcare professionals such as GPs, speech and language therapists, podiatrists, opticians, mental health nurses, dieticians and district nurses had been involved in people's care. Two people we spoke with confirmed they received medical attention as soon as they ever needed it. One person said, "They are very good like that, no hesitation in bringing a doctor." Another person said, "They get you the right treatment from either the doctor or hospital." A relative told us, "They do call the doctor when needed and always keep me informed." Another relative told us they were happy with the way the staff had looked after their relative.

However, we saw in the records of one person who used the service a physiotherapist had identified a programme of strengthening exercises for a person who used the service. A staff member said the daily notes should have a record of when the exercises were completed. We looked back over the last month and could not see if this person had been supported to carry out their exercises. We received a mixed response from staff we spoke with regarding the person's exercise programme and how often it was completed. The deputy manager told us this would be addressed and they would be monitoring this in the future.

One health professional we spoke with told us they received timely and appropriate referrals from staff as required. Another health professional told us, "They flag stuff I would want to know about. I am really happy with them and nothing is too much trouble. The management is responsive; if it needs doing it gets done."

Good

Is the service caring?

Our findings

People who used the service and relatives told us care was good. Comments from people included, "Everyone seems to be happy. They are quite good these people", "They look after our rooms, they are very clean. I'm settled and the staff are really good, they look after you", "It's excellent here, the staff are very good and I'm happy here", "The staff are polite and civil. I just ask for what I want and they bring it to my room. If I ask for something then it comes. If [name of staff member] is going to the shops she'll fetch me what I like", "The staff are very good, they come reasonably quickly when you ring the buzzer. The staff are helpful" and "I like it here." One person told us, "We're all well cared for as far as I know. They're all very good." We overheard one member of staff who responded to a person who had complimented them saying, "That's nice [name of person]. You're lovely too."

Comments from relatives included, "Top notch care", "They've been brilliant and really looked after my mum, handling this end of life period so well", "It's been marvellous for my dad", "They've been fantastic with him, he's been here eight months" and "All of us are very pleased. He's definitely pleased with where he is and the entertainment's great." A family member told us they wanted to participate in their relatives care and told us how thoughtful staff were by providing a foot spa to enable this.

Staff demonstrated they knew people well and were aware of their likes and dislikes. We saw staff treated people as equals which showed how much they valued people who used the service. One staff member said, "I love working with the people here, love being able to make a difference to someone's life in a good way." Another staff member said, "Everyone's just so nice."

One relative told us they had some concerns about their relative showering on their own but were reassured this was not happening. However, they did feel their family member would benefit from more than one shower per week, which was what they said they had been told was available.

Staff told us people showered and/or bathed when needed but were offered this at least every other day. Staff gave clear examples how they encouraged people to maintain their hygiene when they were reluctant to shower. For example, going back to them another time, asking another member of staff to encourage the person or explaining how better a person would feel if they showered. Staff said they would escalate concerns where they felt someone was repeatedly choosing not to wash. One staff member said, "They get offered a bath or shower every day. Everyone gets one at least once a week." The staff meeting records showed the senior team had discussed arrangements to make sure people's hygiene needs were met as they wished.

We looked at daily records, known as progress notes to see if people who used the service received their care and support as planned. A staff member said any personal care carried out such as a bath or shower should be documented when it occurred. We looked at three people's progress notes from the last month and saw on only one occasion was it recorded that a person had taken a shower. Staff said people received baths and showers according to their wishes and confirmed it may not always be documented to show this. The registered manager told us on the second day of our inspection they had made arrangements for

records to be clearer when people had a bath or shower.

We saw mostly positive interaction throughout our visit and the people who used the service appeared relaxed and comfortable with the staff. People looked well cared for, clean and tidy which was achieved through good care standards.

We observed people were treated with dignity and respect. We saw when staff entered a person's room they knocked before entering the bedroom and bathroom and waited to be invited in. We saw staff treating people sensitively and with patience; they got down to people's level when helping them and gave explanations of any interactions. However, on one occasion a person who used the service asked for more biscuits with their afternoon tea. Staff responded to the person's first request for this but ignored their subsequent request and just walked away from the person without any explanation or acknowledgement. The registered manager said they would increase staff awareness and included dignity as an item at the heads of department daily meetings.

People we spoke with told us they were respected by the staff and had their privacy when they wanted it. One person told us, "If the door is shut they don't come in." Another person said, "Yes they always knock on my door." A relative said "If [name of person] was in their room they knock on her door. We have seen this."

Care plans we looked at showed people who used the service or their relatives were involved in planning of care. Some relatives had written a life history for their family member to enable staff to get to know people better. Some relatives had signed care records to show they had been involved in the care planning process in the best interests of their family member. One person we spoke with said, "They keep us informed if we need to know" and "I know about a care plan they talk to me about it." A relative said "We have read it a couple of times. We tell them if we think changes need to be made."

People's religious needs were considered in the care plans we looked at. The care plan for one person who was recorded as being a non-practising Christian stated '[Name of person] is always given a choice if she would like to attend any Church service within the home'. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

Before people moved into the service an assessment of people's care and support needs was carried out. Senior staff carried out assessments and said they then discussed the outcomes of these with the registered manager to make sure the service could meet people's needs.

People's care plans were drawn up using the information from the assessment with the person and their family member if appropriate. Care plans detailed people's needs and gave staff guidance on how people preferred to be supported, what they could do independently and what staff needed to do. The care plans contained sections covering mobility, mental health, cultural and religious needs, senses and communication, eating and drinking, personal hygiene and future wishes. We saw 'Do not attempt cardio pulmonary resuscitation' forms were in people's care plans where appropriate and these were up-to-date. Staff told us they were given opportunities to look at care plans and keep up-to-date with people's needs. They said the care plans were accurate and we saw care plans were reviewed on a monthly basis.

We looked at one person's care plan and the 'resident choices and care preferences' stated, '[Name of person] is able to vocalise her needs appropriately to both staff and others, although at times can be muddled. Staff are to allow her extra time to explain herself'. Another person's care plan recorded their choice around night time care. It stated '[Name of person] is able to decide when she would like to go to bed and this is usually around 8pm but may vary at her choice'.

We saw evidence of life history in people's care plans and saw where people and relatives had been involved in this process. However, the life history for one person who had lived in the home for five weeks had not been completed.

We saw a care plan for one person's who had diabetes which contained relevant information about the care and support staff needed to provide this person and to avoid low blood sugar levels. A number of skin assessment charts had not been completed. This was the case for one person whose care plan stated, [Name of person] is at risk of bruising to lower legs due to resting legs against tables'. Staff told us this was a new document which they were expected to complete.

We found at times the plans were generalised and did not always provide detailed guidance on how people wished to be supported. For example, we frequently saw it was recorded that people needed 'full assistance' with personal care. Another person's care plan for mobility stated the person had a '4 wheeler frame' but didn't use it. It was identified from the notes in the care plan the person had seen the physiotherapist and had been identified at risk of tripping. This was not referenced in the care plan. We spoke with a staff member who accepted the information was missing. The staff member said the reason this had not been done was because the person was new to the service but stated this would be done immediately.

The activities co-coordinator told us, "I keep a record of all the activities and who has attended them and this is then put in people's care plans and if any family member wants to know what their relatives have been taking part in we can tell them." They also said, "I love it, I like to make a difference if I can. If I put a

smile on a residents face I'm happy." The registered manager told us they were currently in the process of recruiting another activity co-coordinator and once the person was in post more one to one activities would be offered to people.

In addition to a programme of in-house activities, a number of entertainers visited the home on a monthly basis to engage people. For example, music for health, a history society and music workshops were held. Activities were provided seven days a week, both in the morning and the afternoon. These included; movies, quizzes, one to one stimulation, ball games. On the first day of our inspection we saw a session called 'balloon swatting' was well attended by both people and their relatives.

People were invited to participate in activities. We overheard one member of staff respond to one person who wanted to join in, but had just been given a drink. They said, "Do you want to finish your tea first and then I'll come and get you." One person said, "They don't say you have to come." Other comments included, "There's usually something to do every day", "I just ask to go out and plant in the garden and they let me. It's alright here, I like gardening." However one person said, "All the activities are on the top floor and I can't make it there. It's a bit boring for me really, not enough to do." A staff member commented, "There's always something going on."

We looked at the management of complaints and found these were appropriately responded to. We saw records of complaints and documented investigations which had been carried out in response. We also saw evidence of responses which were provided to people well within timescales identified in the registered provider's complaints policy.

People we spoke with were happy with the service and the staff. They felt if they had a problem they would be listened to and action would be taken. Comments included, "If we have a problem we can go to the manager she has given us faith we can talk to her about anything", "If I wasn't happy I would tell someone", "No grumbles at all if I had I would tell staff" and "I have no course to complain."

The service had received compliments about the quality of care provided, which included the following comments; 'thank you for caring for [name of person]', 'we just wanted to day thank you for your loving care that you gave to mum' and 'thank you for all the wonderful way you looked after my brother'.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the manager was registered with the Care Quality Commission. The registered manager and deputy manager worked alongside staff overseeing the care given and providing support and guidance where needed. They engaged with people living at the home and were clearly known to them.

Quality assurance systems were in place to ensure the service was monitored and any risks were identified. The provider visited the service regularly to check standards and the quality of care being provided; this included checks on staff training, the environment, medications and care plans. We saw the registered manager reported information on pressure care, weight loss, infections, complaints and staffing, monthly to the provider's head office. We also saw a calendar of audits that were scheduled to take place monthly for 2017. We looked at the medication and care plan audits for January 2017; we noted it was not clear who was responsible for completing the identified actions and what date these needed to be completed. The deputy manager told us they would strengthen the recording within the both audits immediately.

However, from the areas looked at during this inspection it was noted further development and improvement of some documentation was required. For example, people's personal evacuation plans, 'as and when' required medication guidance and some sections of people's care plans. Following day one of our inspection the registered manager had compiled an action plan to implement changes, which included linen changes, more accurate recording of when people had a bath or shower and changes in some medication documentation. During our inspection on the second day the registered manager said, "We got a bit complacent at times."

We saw it was not clear what the role of the team leader was on each floor. One staff member told us the team leaders were responsible for tablets, organising three monthly team meetings and most paperwork including new care plans. The registered manager told us the team leader role was to order medication, carry out supervisions and co-ordinate staff and people's care needs. We saw as part of the registered manager's action plan following day one of our inspection they were in the process of reviewing the effectiveness of the role of the team leader. The registered manager said, "It's up to us to develop a programme of development for team leaders."

Staff told us they enjoyed their role and felt well supported. They said the management team in the home were approachable and they felt any suggestions they made were listened to. One staff member said, "The manager and deputy manager are always available, they are approachable and support us." Another staff member said, "If I have any problems I can go to either [name of registered manager] or [name of deputy manager], they are approachable." Staff told us there was a sense of togetherness and teamwork amongst the staff group. They said, "I do enjoy my work. We all tend to pull together as a team. Another staff member said, "I've got a lovely support team."

Staff told us the registered manager was enthusiastic and committed to providing a good standard of care for people who used the service. One staff member said, "[Name of registered manager] really cares about people." One health professional we spoke with commented on how well the registered manager had

managed the care of a person with complex needs They said, "She was really good and supportive."

The majority of people who used the service and relatives spoke highly of care, support and management of the home. One relative said, "The staff and manager are responsive. I feel welcomed each time I come." Other comments included, "Don't know her name but she is approachable. When we go away she is always available and has our mobile number if they need to get hold of us" and "Yes if not we get the deputy." However, one relative said, "They don't listen to what you're saying in residents meetings. They tried to feed dad pork pie when he has no teeth; I had to raise this more than once. The two staff that I promised wouldn't be working together are, but it seems to be okay; though this is a broken assurance which I have challenged and to which I have not had a satisfactory response. I have to lock dad's stuff up, but the keys and things still go missing. I still think that generally the staff are really good though." In the June 2016 meeting of residents and relatives it was recorded 'All felt they can approach the home manager with any issues, find her approachable as they do with all staff'.

One relative told us they thought they had brought some new pyjamas and put them in their relative's room but could not find them. They were not completely happy in how the registered manager had addressed this. One person who used the service told us at peak times they seem very stretched. There doesn't seem to be any regular pattern to changing the bedding and sometimes I have to ask them to do it."

We saw evidence of staff meetings which took place on each floor of the home and other departments, such as housekeeping and the kitchen. We also some evidence of full staff meetings, although a staff member told us, "We haven't had one for a while." Other comments included "We do get to say our bit, but sometimes it feels like it falls on deaf ears", "It's mainly fact, but you can say anything you want to", "It's an open discussion", "I haven't done a floor meeting yet as such. We've only just started doing floor meetings" and "You just put your views across if you've got any problem." We saw full staff meetings had taken place in December 2016.

In October 2016 from the minutes of the senior/team leader meeting, we saw a discussion regarding having two separate dining sessions in order that people who need assistance with eating could have this dedicated support. During our inspection we saw this arrangement had been put in place and worked well.

Staff told us they were informed of any important issues that affected the service such as feedback on complaints or concerns. One staff member said, "Communication is very good and we learn from any mistakes."

The provider's PIR stated 'Daily 10 at 11 meetings are conducted which are attended by all heads of departments. These meetings are additional to daily handovers. Daily handovers and 10@11 meetings are completed which promotes the well-being of residents and communication between departments'.

Resident and relatives meetings had taken place in January, March, June and September 2016, although not everyone we spoke with was aware of them. Activities, cleanliness, food and staff were regularly discussed and we saw positive feedback at these meetings. In September 2016 people who attended the meeting had suggested a change of mealtimes as they suggested these were too close together. It was recorded other people preferred the mealtimes as they were, although it was noted this would be reviewed on a monthly basis. One person told us, "I don't think we have residents meetings." Some relatives we spoke with were not aware of recent meetings. One relative said, "I think they have them I don't go to them. They talk to people now and then to see what's going on. I think things would get done, it is in their interest to keep people happy." Another relative told us they no longer went to the meetings as "They just don't listen or follow up on action." A third relative said, "I don't know anything. If we were invited we would be interested in

attending."

People were encouraged to share their views and put forward ideas of how the service could improve by the use of annual questionnaires for people who used the service and their relatives. These were collected and analysed to make sure people were satisfied with the service. We looked at the results of a survey from June 2016 and saw the majority of responses were excellent, very good or good. Where the results showed the response to be fair or poor actions had been identified so improvement could be made.