Barchester Healthcare Homes Limited

Castle Rise

Inspection report

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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?	Good

Summary of findings

Overall summary

Castle Rise is registered to provide personal and nursing care for up to 40 people, eight of whom could be people accessing the step down facility. The step down beds are commissioned by Hull Clinical Commissioning Group and used to facilitate an early discharge from hospital whilst a package of care is organised. The service has two floors accessed by a passenger lift and stairs. All the bedrooms are for single occupancy some of which have an en-suite facility. Communal rooms consist of three lounges, a dining room, an activities room and a hair salon. There are toilets and bathing facilities on both floors. The service is located in a residential area with a small car park at the front and enclosed gardens at the rear.

The service 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.

At the last comprehensive inspection on 2 November 2015, we rated the service as Requires Improvement overall. At this comprehensive inspection we found improvements had been made and sustained. There were 36 people using the service at the time of this inspection.

We found the service was safe for people to live in. There were sufficient staff employed on each shift and they had been recruited in a safe and robust way. Staff received an induction when they started work to ensure they were familiar with working practices and people's assessed needs.

Staff had received training in how to safeguard people from the risk of harm and abuse and there were policies and procedures to guide them. Staff knew how to raise concerns should they witness abuse or poor practice. Risk assessments had been completed for people with specific concerns and these provided guidance for staff in how to minimise risk.

We found people's health care needs were met and staff supported them to access community health care professionals when required. Medicines were obtained and stored appropriately and people received their medicines as prescribed.

People's nutritional needs were met. Menus provided choice and alternatives and people told us they liked the meals provided to them; there were special diets such as textured meals, low sugar and high calorie, provided to specific people when required. When there were concerns about people's nutritional or hydration needs, these were monitored and referrals made to GPs, dieticians and speech and language therapists.

People were supported to make decisions and choices. Those people assessed as lacking capacity to make their own decisions were only deprived of their liberty when this was in their best interest, had been agreed with the local authority and was carried out within the law.

We found there was a range of activities for people to participate in. This helped them to be occupied in a meaningful way and to access the local facilities.

People had assessments of their needs undertaken and care plans had been created which guided staff in how to provide care and support that was individual to their needs.

We observed the staff approach was kind and caring, which was confirmed in discussions with people who used the service and their relatives. We saw staff promoted people's privacy, dignity and independence. Confidentiality was maintained, records stored securely and conversations with health and social care professionals were held in the privacy of an office.

Staff received, training, supervision, appraisal and support to ensure they had the skills required to care for people who used the service. The training records identified when training had taken place and when updates were due.

We found the environment was clean and tidy. There was sufficient personal, protective equipment for staff to use when required and housekeeping staff told us they had sufficient cleaning materials.

There was a quality assurance system which consisted of audits, checks, surveys and meetings. These ensured shortfalls were identified and addressed in a timely way. It also ensured people were listened to and their views respected. There was a complaints procedure and people told us they felt able to complain.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were recruited safely and there were sufficient staff on duty to meet people's needs.

Staff had received training in how to safeguard people from the risk of harm and abuse and knew how to raise any concerns to the appropriate agencies.

Medicines were managed well and people received them as prescribed.

The environment was safe and clean.

Is the service effective?

Good

The service was effective.

People's health care needs were met and they received advice and treatment from community health care teams when required.

People told us they liked the meals provided to them. The menus were varied and met people's nutritional needs. Any concerns about nutritional intake were monitored and referred to appropriate agencies.

People were supported to make their own decisions and choices. When people lacked capacity for this, decisions were made in line with the Mental Capacity Act 2005 and in their best interests.

Staff received the right training, support and supervision to enable them to feel confident when supporting people who used the service.

Is the service caring?

Good

The service was caring.

People who used the service were treated with compassion and respect and their dignity was maintained.

We saw staff had developed friendly relationships with people and encouraged them to maintain their independence.

Confidentiality was maintained and people's records were stored securely.

Is the service responsive?

Good

The service was responsive.

People had assessments of their needs and care plans were developed which provided staff with information on how to support them in line with their preferences and wishes.

Staff supported people and responded to their needs in an individual way.

There was a range of meaningful activities for people to participate in within the service and also to enable them to access the local facilities.

There was a complaints procedure on display and people felt able to raise issues knowing they would be addressed.

Is the service well-led?

Good

The service was well-led.

There was an open culture within the service and the main focus was on providing quality care to people who used the service.

The registered manager was very organised and made themselves known to people who used the service and their relatives.

There was a quality monitoring system that enabled shortfalls to be identified and addressed, and learning to take place.

People's views were listened to and acted upon; this reassured people their views were important.

Castle Rise

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 registered 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 31 January and 1 February 2017 and was unannounced. The inspection team consisted of one adult social care inspector and an Expert by Experience [ExE]. An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered provider had completed a Provider Information Return (PIR) prior to the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We checked the PIR and also our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority safeguarding, contracts and commissioning teams, and also health commissioners about their views of the service.

During the inspection we observed how staff interacted with people who used the service throughout the day and at mealtimes. We spoke with 10 people who used the service and three people who were visiting their relative. We spoke with the registered manager and the deputy manager (both qualified nurses) seven care workers and the activity coordinator. We also spoke with an occupational therapist and a dietician.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at six care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as 23 medication administration records (MARs) and monitoring charts for food, fluid, weights and pressure relief. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to

make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included two staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records.

Good

Is the service safe?

Our findings

People told us they felt safe living at Castle Rise. They also said staff answered call bells in a timely way, had time to sit and talk to them and administered their medicines. Comments included, "Yes they come round and make sure you're alright. They come in if you want when I have a shower or a bath. Nurses do my medication", "I like living here; of course I do [feel safe]. They make sure I'm safe in the bath or shower" and "My stuffs safe. One staff helps me in the shower and the nurse comes with my tablets", "I feel safe because of the people who look after me" and "Yes, I love it; the staff are always around and the nurses do my tablets."

One person said, "Safe, oh yes, there's good security. The only thing I'd complain about is that there's no rails in the place. I use my pod and my wheel chair; I had a stroke and I can't walk [unaided]". We noted that in corridors there was a hand rail at one side only; the registered manager told us they would address this straight away.

Comments from relatives included, "I think she is looked after very well; yes, she is safe", "Yes, extremely safe", "Yes, this is a secure building so she is safe", "Yes, there's enough staff on duty", "When I come to visit, there are always plenty of staff on", "There's plenty of staff and we know names", "It's lovely and clean", "The cleanliness of the home is very good" and "I think the home is very clean and looked after very well."

We found staff knew how to protect people from the risk of harm and abuse. Staff had completed safeguarding training and in discussions were able to talk about the different types of abuse and how to recognise potential signs and symptoms. They knew how to deal with any allegation of abuse and how to report poor practice. Staff completed risk assessments for people, for example, falls, moving and handling, nutritional intake, choking, pressure ulcers, distressed behaviour and the use of equipment such as bedrails. The guidance in risk assessments helped staff to manage risks without impacting too much on people's skills and independence.

The administrator described the system in place to manage a small number of people's personal allowance; most people had family involved for this task. The system was clear and ensured people's personal allowance was protected and managed appropriately.

We found people received their medicines as prescribed, which was confirmed in discussions with them. People's medicines in daily use were stored in locked cupboards in their bedrooms. Additional stock and those medicines which required more secure storage were held in locked cupboards in the nurse's office. We saw there was a system of stock checks and re-ordering medicines to make sure people did not run out. Checks were also made of people's medication administration records to ensure they were signed appropriately. There were protocols in place for medicines prescribed 'when required' (PRN). This made sure staff had clear guidance on when they should be administered, the frequency of the dose and the length of time between doses. Only qualified nurses administered medicines to people; they had received training and abided by the Nursing and Midwifery Council (NMC) code of practice on medicines administration. There were some minor recording issues found which were addressed on the day with

nursing staff.

We found staff were recruited safely. Employment checks were carried out prior to staff working in the service. These included, completing an application form so gaps in employment could be explored, obtaining references, having an interview and a check with the disclosure and barring service (DBS). The DBS is a national agency that holds information about criminal records. The recruitment process helped to ensure people who used the service were protected from individuals who had been identified as unsuitable to work in care settings. The registered manager also made sure nurses had an up to date registration with the NMC and they said any restrictions on their practice would be noted and discussed.

We saw staff completed an initial three day induction following recruitment, which included set training. Staff also completed workbooks which incorporated the national Care Certificate; there were separate books for nurses and care workers. There was a buddy system for new staff to work alongside more experienced workers, observations of practice to check competences and a three month probationary period which could be extended if required. The induction helped to ensure new staff gained skills and insight into how they were expected to carry out their new roles.

There were sufficient staff on duty to meet people's assessed needs. Staff rotas showed there were two nurses and six care workers on duty during the day and one nurse and three care workers at night. In addition, there were three care workers each day employed to provide various amounts of one to one support for specific people who used the service. There were nine hours of domestic cover each day, maintenance personnel when required and an administrator five days a week. Catering and laundry were carried out at the main Castle Care complex and brought to the service each day. However, there was a hostess on duty to help serve meals and drinks from 8am to 2pm and again from 5pm to 7pm. The ancillary staff meant care workers could focus on care tasks. An activity coordinator was on duty from 10am to 4pm five days a week and the registered manager was supernumerary to the rota. There was an on call system of management support for staff out of usual working hours.

The environment was safe and equipment used was checked, serviced and maintained. The registered manager held records of when checks and services took place, for example of moving and handling equipment such as the lift and hoists, the nurse call and fire alarm system, hot water outlets, utilities, electrical appliances and the calibration of weighing scales. There was an environmental risk assessment in place and health and safety meetings were carried out to discuss issues and learn from events in other services in the company. There was a business continuity plan should any emergency occur and people who used the service had personal plans for any potential evacuation of the building. This helped to ensure staff knew how to evacuate people safely if required.

The service was clean and tidy and staff had access to personal, protective equipment such as gloves, aprons and hand sanitiser. New hand towel and soap dispensers had been installed in each person's bedroom for staff and relatives to use when required.

Good

Is the service effective?

Our findings

People told us they received effective care and they liked the meals provided to them. They also told us staff seemed skilled in caring for them. Comments included, "The staff will get me anything I want to know; the staff here are excellent", "They ring an ambulance if I fall and get the doctor if I'm sick. I see the dentist, optician and chiropodist" and "My GP comes out if I'm poorly."

Comments about meals included, "I can have bacon and eggs for breakfast; it's always hot. They bring me drinks in the day", "Plenty of drinks. The food, well it depends; it's hot and the portion size is ok", "I eat all the food; it's good, yes" and "They spoil me; I order things and they get it for me, especially at tea time. They get things that aren't always on the menu. I say, "Can I have cheese and biscuits?" and staff say, "I've already ordered them for you" and "Beautiful food." One person who used the service told us they would like the food to be served warmer. This was mentioned to the registered manager to address.

Relatives comments included, "I think the staff are very skilled", "They know how to settle her when she's distressed", "I think her health needs are cared for extremely well", "They [staff] write everything down, meals and drinks, so they know their intake" and "The staff are very good with her and she lets them know what she likes and dislikes [food]."

We found people's health care needs were met. In discussions, staff accurately described to us how they prevented pressure ulcers from occurring, how they delivered catheter care, how they recognised the first signs of a urinary tract infection or a chest infection, and the action they took to prevent people's health deteriorating further. The care files showed people had access to a range of health care professionals when required such as GPs, consultants via outpatient's appointments, dieticians, physiotherapists, specialist nurses, opticians, chiropodists and emergency care practitioners. The service had eight placements for people who required a short stay following discharge from hospital until care packages in the community were arranged. The two health professionals seen during the inspection said, "Excellent; the patient seen today was managed well and nutritionally stable due to clinical plans being adhered to" and "I have visited twice and have had no concerns; on my two visits, the skill mix seems appropriate."

We saw people's nutritional needs were met. A nationally recognised risk assessment tool was used to determine any nutritional risks and people were weighed in line with the results. This meant some people were weighed more frequently than others. We saw referrals to dieticians and speech and language therapists had been completed for advice and treatment for some people. We saw staff used guidelines from the National Institute for Health and Care Excellence (NICE) to determine the optimum levels of fluid intake for people, based on their weight and medical condition. Staff completed monitoring charts for people at risk and recorded their food and fluid intake; the amount of fluid staff were to encourage people to aim for was indicated on the monitoring charts. This process helped staff to see when people's food or fluid intake fell below the optimum level and they could take corrective action throughout the day and night.

Menus provided a range of nutritious meals, with choices and alternatives. We observed the lunchtime

experience on both days of the inspection. Lunch arrived in a hot trolley and staff served it to people; this meant they were able to provide people with the portion size of their choice. Meals of different textures were provided, for example, pureed, and we saw these were presented as separate food items. Staff assisted specific people to eat their meals in a sensitive way and at an appropriate pace.

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 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 found the registered manager was very knowledgeable about the criteria for DoLS, who had a DoLS authorised and which people had an application made and authorisation pending. At the time of the inspection, DoLS had been applied for 16 people, three of which had been authorised, seven assessments were underway and the remainder were yet to be assessed. There was evidence the registered manager had followed up applications with the local authority to check on their status. This meant the registered provider and registered manager were acting within MCA legal framework.

In discussions, staff were clear about how they obtained consent from people prior to carrying out care and support tasks. They said, "We ask people and we read what's in the care plans" and "Ask people and explain things; make sure they have a choice and we go back later if necessary." Staff were clear about the action to take if a person declined care and they described the distraction techniques and support they used for one person who sometimes became anxious. A health professional said, "On both visits, staff have accompanied me on the initial contact to gain consent and offer support." We saw assessments of people's capacity to make their own decisions had been completed and when people lacked capacity, best interest meetings had been held with relevant people present to support decision-making.

Records showed staff had access to supervision meetings and training courses which provided them with the support, skills and knowledge they needed to carry out their roles. In discussions, staff confirmed they completed training which was a mixture of face to face training and on-line courses; they also confirmed they had supervision meetings and annual appraisal. Staff said, "The training is good; we have a percentage of face to face training but more e-learning now", "Supervision is monthly" and "We have refresher training yearly, booklets to complete on skin care and practical training like moving and handling, fire and CPR (cardio pulmonary resuscitation)." We saw the training included a range of essential courses and some staff had completed additional ones such as end of life care, mentorship, customer care, and dysphagia and choking. One nurse had completed a course on alternative therapy. The registered manager showed us a learning and development plan they had collated regarding additional training for the nurses. A folder had been set up with information to assist nurses in the revalidation of their registration. Revalidation is the new process that all nurses and midwives will need to go through in order to renew their registration with the Nursing and Midwifery Council.

The environment was suitable for people's needs. There were grab rails in corridors, toilets, bathrooms, shower rooms and moving and handling equipment to assist people. There was signage to remind people living with dementia where to locate the toilets. The registered manager told us they had just signed up for a new company to provide vision care/eye tests and they were to choose 25 signs to use around the service; they were in the process of deciding which signs would be the most suitable. We saw the main corridors had a grab rail at one side only and mentioned this to the registered manager to address.

Good

Is the service caring?

Our findings

People told us staff were kind and caring and their privacy and dignity was maintained. Comments included, "The staff are excellent", "I get everything I need", "I was fully involved in my assessment and I've got a care plan in my folder", "Visitors can come any time", "My family and friends are involved in my care; you can do what you like. It's quite good actually, better than I thought it would be" and "The staff are caring, kind and compassionate and the visiting is open".

During the inspection, one person who used the service was informed inspectors were available to speak with them. They decided to send an email to the registered manager with their comments. They said, "Your nurses are great from [name] who is so efficient, professional and knowledgeable to [name] who is full of fun and all the others are very good. Your carers are fantastic especially the ones on the upper floor who look after me. [Name], my keyworker is great; nothing is too much trouble for her and she is often here after her finishing time and [name] is happy and smiling. I find all the staff caring and considerate. Just to finish [registered manager's name], I would say that if things stay as they are I would be happy to spend the rest of my life here at Castle Rise."

Relative's comments included, "They are a fantastic group of carers", "The staff are very caring and kind to [person's name] and also to me" and "The staff are very caring and kind."

People were able to remain at the service for end of life care if this was their choice. Some thank you cards were from relatives of people who had received end of life care at the service. Comments included, "She was settling well and loved the way you let her follow you around and help you. You have all been wonderful and we are very grateful she had her last few months in comfort and happiness" and "Thank you for looking after my mother; you are all brilliant workers. I know it's not an easy job – keep up the good work."

We observed the staff approach was kind and caring. We saw staff provided explanations to people before carrying out tasks, they ensured choices were made, for example at meal times, and they involved people in decisions. One person liked to have their bedroom arranged in a certain way and not to have their belongings touched by staff. We saw staff respected this but also negotiated with the person to ensure the room was cleaned and the belongings did not become a hazard. Care plans provided information about people's likes and dislikes and how they preferred to be cared for; staff told us they had the opportunity to read care plans.

We observed staff speak to people in a respectful way and also had a friendly banter with them. They got down to people's level to talk to them when they were sitting in a chair, made eye contact, smiled and were appropriately tactile, comforting people when required. During the short observation for inspection (SOFI), we noted there were some missed opportunities for staff to interact with a person when they were walking through one of the lounges. This was mentioned to the registered manager to raise with staff. When staff did stop to interact with the person, this was completed in a nice way.

We saw staff promoted people's privacy and dignity. Two people, when they were in bed, preferred to have

light bedclothes and there was the potential for these to be kicked off. Staff had provided a light voile curtain at the doorways to protect their dignity and privacy at the same time enabling the door to be left open so the people did not feel isolated. In discussions, staff described how they would promote privacy and dignity. They said, "Keep doors shut and close curtains [during personal care]", "We knock on doors before entering and some people have a net curtain at the doorway" and "We keep people covered up with a towel [during personal care]." Each person had a bedroom for single occupancy which afforded them privacy and space to be alone should they wish it. The bedrooms had a lockable facility to store personal items securely if required. We saw 'do not disturb' signs were used on the doors to alert staff and visitors that people may not want them to enter. The service had two sets of toilets that were cubicles; work has been planned to change these into walled rooms to maintain privacy when the toilets were used.

We saw staff encouraged people to maintain their independent living skills as much as possible. One person was supported to return their lunch tray to the kitchen, to make drinks for themselves and also to complete their laundry. Although laundry was carried out at the Castle Care complex off site, the registered manager showed us a domestic washing machine and drier which had been installed to assist people if they wanted to do their own. The dining room in the service had a low work surface at one end which incorporated a sink so people who used wheelchairs could use them. There was a juice and water machine to enable people to help themselves and a vending machine with items for people to purchase.

We found people who used the service were provided with information around the service. There were notice boards which included information about meetings, how to make a complaint, advocacy services, the last inspection report and scheduled activities.

We saw staff maintained confidentiality. They completed telephone calls and discussions about people's health care needs in private in the nurse's office or the registered manager's office. People's reviews were held in their bedroom or a quiet lounge. People's health and care files and medication administration records were held securely in the nurse's office. We saw symbols were used to indicate specific information in people's bedrooms, for example, when people had a 'do not attempt cardiopulmonary resuscitation' order in place; the symbols helped to promote confidentiality. Records were also held in computerised form and the registered manager confirmed the computers were password protected. The registered provider was also registered with the information commissioner's office, a requirement when computerised records are held. Staff records were also held securely in the administrator's office.

Good

Is the service responsive?

Our findings

People who used the service told us staff responded to their needs. Comments included, "I have a Zimmer now [walking frame]; I couldn't manage without it. I didn't have it before and I always felt like I was going to fall backwards." People also told us staff listened to them if they had complaints or concerns. They said, "I could talk to the staff about my worries", "I complained and they sorted it out", "I'd tell the staff if I was worried and the nurse if I wanted to complain", "I'm not worried in here but I could talk to the staff if I was" and "It depends what the complaint is, but I think I could talk to [registered manager's name]."

Relatives said, "[Registered manager's name] is very good with any response I have needed about my relative", "I have raised concerns about one thing and got a good response back" and "Yes, we can raise concerns if we need to."

Comments from health professionals about the responsiveness of the service included, "I'm contacted when any issues arise."

People had assessments of their needs undertaken, including identification of any risk prior to admission to the service. Those people admitted for permanent residency had a more comprehensive assessment than those people admitted from hospital into the step down beds, used as an interim measure for two weeks until a care package was arranged in the community.

The registered manager told us they had instructions from the commissioners of the step down beds and the hospital discharge liaison team that they would prefer them not to attend the hospital to complete assessments as this could affect and slow down the discharge process. The registered manager felt sufficient information was gathered over the phone and a form was completed when this occurred. They also obtained an immediate discharge summary and a discharge check list from the hospital. They told us they made appropriate referrals to health professionals when required following a meeting to discuss community arrangements.

We saw people had care plans which provided staff with guidance in how to support them to meet their needs. People admitted for permanent residency had comprehensive care plans which were detailed with preferences and clear guidance. For example, one person had a care plan to manage their diabetes and insulin injections; each care task was detailed such as monitoring blood sugar levels, what to do if the levels dropped below a certain amount and when it would be necessary to withhold insulin. Another person required skin care and their care plan gave clear instructions to staff of where vulnerable areas were and what they had to do to protect them. We saw people had appropriate wound care assessments and plans to treat and manage them effectively. A health care professional told us they had spoken to the registered manager about a missing care plan regarding the management of one person's behaviour which could at times be challenging to the service and other people. We checked and this care plan had been put in place since the discussion.

The people admitted to the step down beds had basic plans of care which could be enhanced by more

personalised information. This was confirmed in a discussion with a health professional prior to the inspection. It was recognised that people were admitted to the beds for periods of time up to two weeks, so there could be a rapid turnover of occupancy. It would be difficult to have the same level of information as those people in permanent residency whose care plans were developed over a period of time. However, the registered manager spoke about a new tool the company had been enhancing called 'Getting to know me'; this was a very person-centred document aimed at ensuring staff gained full insight into the people they supported. Until this was in operation fully, the registered manager told us they would develop a shortened version for people admitted to the step down beds, which could be completed on their first day of admission to explore their previous routines, likes, dislikes and preferences.

It is recommended the registered provider follow through with plans to enhance the care plan information for people who use the step down bed facility.

We saw there were specific instances when staff had responded to people's needs in an effective and caring way. For example, the activity coordinator supported one person to have walks to help them relax and accompanied another to visit second hand shops to purchase items. Birthday cards were purchased for people and cakes ordered at the start of the year to make sure their birthdays were not missed. One person who used the service was isolated in an upstairs bedroom but didn't want to move downstairs. The registered manager told us how they redecorated the downstairs bedroom and the person liked it; this 'tempted' them to move in. They now came out of their bedroom and walked about downstairs. The registered manager supported one recently bereaved person who used the service and their family in a very caring and compassionate way.

We saw there was a range of meaningful activities for people to participate in. An activity coordinator was employed for 30 hours a week; they completed one to one activities with people and also group sessions. There was a specific budget for materials and prizes, and an activities board in the corridor near the main entrance which clearly showed all the activities for the week; these activities were flexible within the time table and adaptable to suit people's needs. The activities included ball games, reading, reminiscence, craft work, pampering sessions, quizzes, bingo, baking, watching films, seasonal parties and themed food nights. There were trips out to local museums, coastal towns, shopping, walks and visiting entertainers to the service. Two people who used the service had an internet connection and another person used the computer set up in the dining room. The activity coordinator also takes people out to use local opticians and told us of a planned garden party later in the year.

We found the activity coordinator was enthusiastic about their role. They said, "Some people prefer to sit in their rooms and do an activity with me. I take most residents out and I try to involve them all. Activities can be a lonely job trying to fill 32 people's lives with things to do but I've been doing it 11 years and I love it." The activity coordinator told us they attended meetings with other activity coordinators a few times a year to exchange ideas. Records were made of all the activities people participated in and whether they enjoyed them. A relative said, "Lots of daily activities are planned and [service user's name] can get out into the community."

The registered provider had a complaints policy and procedure, which was on display on the notice board. The procedure identified how to make a complaint and who to, timescales for resolution and how to escalate to other agencies. People told us they felt able to raise concerns with staff, the registered manager or other members of the staff team. Staff knew how to manage complaints. We saw the service had not had any formal complaints in the last year.

Good

Is the service well-led?

Our findings

At the last inspection in November 2015 we rated this well-led section as Requires Improvement as the manager in post had not completed registration with the Care Quality Commission (CQC). Since then the manager has completed registration with CQC. We found they were aware of their registration responsibilities and completed notifications to us in a timely way. Notifications of incidents which affect the health and safety of people who use the service are required by regulation and enables us to check how they are being managed.

People who used the service knew the registered manager's name and felt comfortable talking to them. Comments included, "They [registered manager] had a chat to tell me what's what; I think a lot of [registered manager's name], the boss. I can talk to the staff - they are genuine."

Relatives also had positive comments about the way the service was managed. They said, "The staff are friendly and attentive", "I think the service and manager is very good; they are all doing a good job of it. She receives good care and staff ask for my views on the care sometimes" and "The service of the home is to a high level."

Health professionals stated, "It appears well-led. The care plans are very clear; staff appear knowledgeable and interested regarding the client's needs" and "Communication with management is good. Complex care is discussed and meetings arranged when possible."

We spoke with the registered manager about the culture and values of the organisation. They described this as 'open and honest', as being focussed on people who use the service and said that senior managers were supportive and very approachable. In discussions with members of staff they said, "The change has been massive; we have good leadership which involves everybody now. It's a good company and a fantastic home; it's 'their home' [people who use the service] and staff will do the extra things because of that", "It's very friendly and like a second home", "The manager is very good; she sorts things out and you can take problems to her", "Morale is good", "The manager is involved and very caring towards the clients; everything is centred around clients", "She is approachable and would listen" and "It has improved in my eyes and the credit has to go to [registered manager's name]. We have good team work and we are very settled now." Staff told us there were reward schemes such as vouchers for long service, 'Refer a Friend', 'My Rewards' and Barchester Care Awards. The registered manager told us the registered provider had an 'It's all about You' website and App for staff. This provided information to staff about a whole range of employee issues, news and announcements and guidance.

We saw there was a quality assurance system which included audits and checks to highlight shortfalls to address, and surveys and meetings to establish people's views. The audits included a range of topics; some were weekly such as medication administration records and some monthly, for example, care records, accidents, hot water outlets and bedrails. The audits covered clinical issues such as infections and any pressure ulcers experienced by people who used the service. The environment was checked for cleanliness and any routine maintenance. Infection prevention and control was checked which included hand hygiene

assessments for staff using an ultraviolet machine. The registered manager completed spot checks out of usual working hours and we saw records of those completed in September (19.30 to 21.00), November (01.40 to 04.45) and December 2017 (05.30 to 08.00). These included observations of staff and people who used the service, a check on security arrangements and staff uniform, and assessment of specific records. The registered manager told us they completed a walk-a-round each morning to speak to people who used the service and staff, and to show they were available. Although this was not documented, it was clear the registered manager knew all the people who used the service and their relatives, and they knew her.

The registered manager showed us a monthly self-assessment of the service which included areas such as complaints, accidents and any safeguarding incidents, nutrition, weight concerns and other clinical issues. The information was held electronically and submitted to a divisional clinical lead at the end of each month; they would contact the registered manager to discuss any concerns and the action taken to address them. There was also a two monthly 'quality first visit' completed by the regional director and audits completed by the registered provider's 'regulation team'. We saw the report from the 'regulation team' visit completed in October 2017 which was linked to the questions CQC ask when inspecting; is the service safe, effective, caring, responsive and well-led. This included an action with timescales for the registered manager to work towards. These measures helped to ensure senior management were aware of issues within the service and to enable them to monitor action plans when shortfalls were identified. We saw the central action plan produced by auditors which was risk managed by the use of a traffic light system and included timescales for addressing issues. The regional director discussed the action plan progress with the registered manager when they completed visits to the service.

The supplying pharmacy visited to audit medicines management and the registered provider had commissioned an external agency for a food safety check in March 2016. There were no issues identified from these audits.

We saw an annual survey had been completed by people who used the service and their relatives and facilitated by an external agency. We saw the results and an action plan from the 2015 survey; the results of the 2016 survey, carried out at the end of the year, were being collated. There was a suggestion box in the entrance which was checked at the end of each month and feedback cards on the dining table to record any issues with meals. There was a 'You said, we did' poster on display which showed us the registered manager and staff had listened to people. For example, there had been some comments about the laundry experience so a washing machine and drier had been installed in the service so people could wash items on site; the main laundry facility was located off-site at the main Castles complex.

Staff told us communication within the service, and between senior managers and the service was good. There were bulletins keeping people informed about issues Barchester-wide and methods of communication within the service. There were monthly meetings for people who used the service and their relatives and also for the staff team. The minutes were detailed and contained action points with staff identified to follow them up. There were short, daily 'department stand up meetings' which enabled a quick discussion regarding admissions to the service and discharges, any concerns or accidents, clinical overview, any complaints or niggles and any housekeeping to address. This enabled the registered manager to be informed of issues and also to pass on information. There were shift handovers meetings to ensure important information was passed on and a diary system to remind staff about appointments for people who used the service. There were notice boards around the service and in the staff room.