Ideal Carehomes (Number One) Limited

Newfield Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Newfield Lodge took place on 28 February 2017 and was unannounced. The previous inspection had taken place in February 2016 and the home had been rated as requiring improvement overall, with a rating of good in the safe, caring and well led domains. During this inspection we checked to see if any improvements had been made.

Newfield Lodge is a purpose built care home for 64 people, divided into four areas, two of which specialise in the care of people with dementia. On the day we inspected there were 56 people living in the home. There was a registered manager who was available on the day we inspected. 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 were safe as staff demonstrated an in-depth understanding of people's individual needs based on their experience and knowledge gained through care records. Staff knew what constituted a safeguarding concern and were aware of how to report such issues. Any incidents were considered to see if they could have been prevented or if procedures needed to change, which showed the service was able to challenge itself.

The service had robust and rigorous risk assessments in place to minimise the likelihood of harm whether through the use of equipment or people's behaviour. These were regularly reviewed and updated, and provided clear direction for staff in how to handle such situations.

Staffing levels were appropriate on the day we inspected and ensured people had their needs met in a timely manner. Medicines were administered, recorded and stored safely.

We saw in records and by speaking to staff there was an ongoing supervision and training schedule which supported staff to develop and progress in their own development. Staff were encouraged to challenge and offer new ideas if they could see areas for improvement. Staff also told us they felt confident in their roles which we observed in their interactions with people in the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The service was acting in accordance with the requirements of the Mental Capacity Act 2005 by ensuring that people who lacked capacity to make specific decisions had appropriate assessments in place to support staff to make decisions in their best interests. However, some of this was not always recorded correctly. Where people were not able to assess risk to themselves or did not have the freedom to leave, Deprivation of Liberty Safeguards were in place.

People were supported with their nutrition and hydration needs, and the dining experience in the communal area was very good. However, there needed to further monitoring of people who chose to remain in their own rooms as we saw meals and drinks were left. The home did have robust weight monitoring plans in place and people accessed support as needed.

We found people had regular access to external agencies as required and regular meetings and information was shared when needed between such services to maintain people's optimum care.

Staff were patient, caring and kind and people responded well to attention. There was evidence of a good rapport between staff and people using the service and we saw that people were encouraged to make as many decisions for themselves as possible during the day. The service demonstrated a consistent culture of respecting people's privacy and promoting their dignity.

People had access to a range of activities both within and outside of the service. We saw care records were clear and detailed, focusing on the individual, emphasising key attributes and provided information about how best to support someone. Records were easy to navigate and it was evident from staff discussions that they were used regularly as staff knowledge was current.

Complaints were handled well, with apologies being offered if necessary. Thorough investigations took place and follow up actions implemented such as staff supervision or further training. The home had received many compliments and positive feedback.

People and staff were content and enjoyed being at the service and the home had a positive and inclusive atmosphere. Staff felt supported and were encouraged to offer new ideas and develop new ways of working if this resulted in better outcomes for people in the service, and were also able to be honest with their views as observed in staff meeting minutes. The registered manager provided consistent and transparent leadership which was observed in their approach with both people living in the home and the staff supporting them.

Quality assurance measures were effective, ensuring no concerns were missed and provided evidence of a well-managed and robust home which sought to provide high quality care for all the people living in it.

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 were safe as staff had a solid understanding of how to identify and report any concerns.

Risk assessments were detailed and based on individual need with clear guidance for staff.

Medicines were administered, recorded and stored in line with guidelines and the service had an appropriate level of staffing to meet people's needs in a timely manner.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were supported with regular supervision and training, and all had received an induction.

The service was acting in accordance with the requirements of the Mental Capacity Act 2005 and people's consent sought wherever possible. However, more evidence was required of best interest decision making.

People were supported with their nutritional needs which varied in complexity across the service within the communal areas but there needed to be closer monitoring of people who chose to remain in their rooms.

People had access to health and social care support as required.

Is the service caring?

Good

The service was caring.

Staff were consistently patient, caring and kind and engaged with people while respecting their right for privacy.

We saw good examples of dignity being respected and people being encouraged to make as many decisions as possible themselves.

Is the service responsive?

Good

The service was responsive.

People were supported to undertake activities of their own choosing and care records were very person-centred and detailed.

Complaints were handled in a timely and thorough manner with actions and apologies being offered where necessary.

Is the service well-led?

Good

The service was well led.

People were happy and contented and staff expressed how much they liked working at Newfield Lodge as they felt supported and valued.

The service had a passionate registered manager who constantly sought to improve the service and had systems to measure progress, consistency and quality of care support.

People's views were regularly sought and listened to and the home had a positive and inclusive atmosphere.

Newfield Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 February 2017 and was unannounced. The inspection team consisted of three adult social care inspectors and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert we used had knowledge of older people's services and care of people with dementia.

Before the inspection the provider 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. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. We also reviewed all information we held about the service including notifications and other intelligence from the local authority.

We spoke with fifteen people using the service and nine of their relatives. We spoke with seven staff including three carers, two senior carers, the care manager and the registered manager.

We looked at six care records including risk assessments, five staff records, supervision records, minutes of staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Good

Is the service safe?

Our findings

One person said "I have my own room but there are people around if I need anything or want company." Another told us "I do feel safe here." Two further people said "We feel safe and have no problems" and "There are plenty of people around." One relative who visited the home often said "I have never seen anything that has concerned me."

Staff were able to explain what abuse may look like and one staff member said "If there is an altercation between two people we would put this through to the local authority safeguarding team." They also said abuse could be "physical, emotional, mental or neglect" and had understood the importance of how to address someone respectfully. We looked at safeguarding records and found incidents were recorded and reported appropriately including the wishes of the person as to their preferred outcome and how staff had intervened to prevent further harm. Part of the monthly analysis of the incidents included consideration as to how things may have been dealt with better. The registered manager discussed one situation which had resulted in changed practice as a consequence, showing they took this area of responsibility very seriously.

People who chose to remain in their rooms had access to a call bell and sensor mats were in place for those who were likely to try and get up unaided but needed staff support. The registered manager explained the call bell times were logged and checked monthly. We looked at these records and it was evident calls were usually answered within two minutes. What was not always evident was the reason why a few calls had taken longer. The registered manager agreed this needed further analysis to provide meaningful data. They explained it had recently been used to show one person how much call intervention they had received when their perception was different. This had allayed the fears of visiting relatives who were concerned that care needs were not being met.

On the day we inspected there were two senior care staff and ten carers on duty in addition to the care manager, front of house manager and the acting deputy manager. The registered manager was also available. We checked the staffing rotas and saw nine carers had been rostered to work. The registered manager advised us each person's dependency level was considered and staffing levels could be increased if needed to manage trips or activities. The dependency tool identified where people's needs had increased or decreased meaning support could be adjusted as required. One person we spoke with told us "It's usually the same people and they are brilliant." A relative visiting the home said "I am always able to see staff and they always let me in." Staff appeared well known by people in the home showing the staff team was stable.

Staff we spoke with were happy with the staffing ratios. One staff member said "It's a stable staff team. There are no problems with staffing levels. We work really well as a team." Another staff member said "There are enough staff on shift." Staff appeared to be well organised and knew what they should be doing during a shift. A further staff member said "Yes, there are loads of staff and this has improved since the registered manager came here." One staff member also spoke with us about extra staff during early evening to support people living with a diagnosis of dementia who could be increasingly anxious during this time. This helped alleviate pressures for staff who were assisting people to bed and the staff member said "I feel I can do my job properly."

The registered manager advised us "Staff are allocated a unit for each shift and all have access to phones in the units so they can request extra support if needed." One staff member told us "Most days there are thirteen staff on duty but sickness can affect this." They also said there were bank staff who could be called on if needed. The registered manager implemented a strict absence policy and this had reduced occasional absence and they also said they were very 'hands on' and supported staff as much as possible. We checked staffing rotas and saw appropriate cover had been arranged for each shift.

We checked staff files and found all necessary checks had been conducted prior to employment. Interview notes showed in depth questions to ensure staff recruited had the right aptitude for the post. References were requested and identity checks carried out including DBS (Disclosure and Barring Service) Checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Risk assessments were generated from a person's initial assessment which took place prior to admission to the home. Risk assessments were in place for all key areas such as pain levels, dependency needs, behavioural concerns, continence management, falls, nutrition and moving and handling. Dependency needs considered the level of support needed with personal care, nutrition, communication, mobility and behaviour among other areas. People with more complex behavioural needs were supported by staff who were provided with person-specific distraction techniques such as singing a certain song. Moving and handling assessments considered everyday transfers such as from bed to chair and any bathing support required. We found these were checked monthly and updated in the interim if an incident occurred

The registered manager explained risk was managed in different ways within the home. For example feedback from families or visitors which highlighted any concerns was immediately acted upon and the evidence of this shared with them. The registered manager explained one of their most significant impacts had been in developing staff to fulfil their roles to ensure all were fully aware of the expectations and felt confident in performing their various duties. This meant senior staff took the lead in assessing risk and developing actions to minimise this. The completion of monthly audits including those for equipment such as bed rails, monitoring people's weight and skin integrity meant risks were regularly reviewed and measures put in place to reduce wherever possible the likelihood of harm. If needed people were assessed more often and families kept informed if the home became concerned.

Accidents and incidents were logged in depth on a falls log and any injuries noted on a body map, with copies kept in each person's file. Following each fall, care records and risk assessments were updated and any necessary external input requested such as from the local falls team. Monthly analysis took place to determine any trends and this included considering the location of the person, the time of the accident and whether any injury was sustained. Falls were colour-coded on a monthly calendar sheet to provide an 'at a glance' record of the frequency of people's falls which again helped identify any key concerns. Individual tallies were assessed against previous numbers of incidents and a record of all action taken thus far was noted. This showed the home, although having a high number of falls, was addressing each one as far as possible and was attempting to minimise the risk of future harm.

One staff member was able to explain how they provided pressure relief. They discussed the specialist equipment including mattress and cushion, and the importance of regular bed rest for this person. For people with an electronic care record the i-pad alerted staff as to when their next positional change was due thus ensuring people received this care support when it was needed.

Most of the people we spoke with said staff looked after their medication and brought it to them regularly, explaining what each item was for. Two people managed their own medication which was stored in their

own rooms in locked cupboards.

We observed people being supported with their medication. This was done sensitively and patiently by staff who offered people water and ensured all medication had been taken as prescribed. We heard one staff member discreetly ask someone if they were in pain and then explain to them what the medication they were being given was. We asked the staff member the process they followed when administering medication and they advised us "I always check it's the right person, the right dose and then pop the medicine into the dispensing cup." After they had 'popped' the medicine out of the blister pack they dotted the medicine administration record (MAR) and then signed it after they were sure the person had taken their medication. Between each person receiving their medication the blister packs were returned to the trolley which was duly locked. This demonstrated robust medicine administration procedure.

Topical medication was recorded on a topical medication application record and a body map directed staff where to apply the cream. PRN (as required) medication was noted on separate sheets with instructions as to when to administer and why. This helped staff judge when to give such medication. The staff member we observed told us controlled drugs were administered to people after everyone had received their initial medication as this needed two members of staff. They also said they tended to work on the same floor to ensure continuity for people and this meant they were aware of how people took their medication. We did note the checks on the controlled drugs cupboard were only recorded sporadically but there were no discrepancies with the contents.

We checked the treatment rooms and found everything to be in order. The fridge temperatures were checked and were within the correct ranges and all the contents were in date. On the wall we noted a list of people who had to receive medicines first thing in the morning and also those whose medicine was only administered weekly so all staff knew who to check. Staff competency checks were conducted which included three observations assessing preparation, administration and record keeping.

We also looked at the medicines file for each floor. There was a medication policy confirmation sheet signed by all staff involved in the administration of medication and a compliance handover sheet for each folder containing the unit's MARs to encourage staff to check on each medication round that there were no issues with the administration or recording. Where errors had been noted an action point was highlighted and completion dates shown meaning the staff had followed up any issues promptly. Stock levels tallied with administration records and creams and boxed medication had the date of opening recorded on them to ensure they were not used beyond their expiry date.

One person said "You don't get the smell here you do in some places." Another person told us "They clean everyday including weekends." All the en-suites, bathrooms and toilets were all very clean. The overall environment was light and bright. I was told that the carpet was new throughout and many of the chairs had recently been replaced. Bathrooms were appropriately stocked with personal protective equipment such as gloves and aprons.

Equipment had been checked in line with Lifting Operations and Lifting Equipment Regulations including the lifts, hoists and all slings. The home had a comprehensive maintenance programme which included checks on the external and internal of the premises such as window restrictors, wheelchairs, hoists and bed rails. Fire protection equipment was also subject to regular checks and we saw a recent fire evacuation drill had taken place.

Requires Improvement

Is the service effective?

Our findings

All people we spoke with were positive about the food. One person said "The food is pretty decent and the chef is smashing." Other people told us "I quite like the food, can't grumble" and "If I don't want a hot lunch, they will make me a sandwich." Two other people told us they had enjoyed their lunch. When we asked if there was a menu, one person told us "A weekly menu is pinned to the noticeboard in the corridor" which we saw. We observed the chef visit the dining room to speak with people and ask if the food was good.

The dining room was nicely presented with tablecloths, napkins, condiments and flowers in vases. Food was served from a trolley in the dining rooms. It looked and smelled appetising and there was plenty of it. People had a choice of two hot meals at the time, followed by dessert, all offered at a leisurely pace. Some people ate their meals in the lounge area through choice and we observed the registered manager joining people to have their meal. We also observed some people had their own personal mugs and cups. Staff addressed people by name and offered them a choice of meal including a second helping. Orange or blackcurrant juice was offered to each person with their meal and tea offered afterwards. A selection of fresh fruit was available for people to eat when they wished. The atmosphere was happy and jovial. The registered manager had advised staff in a recent staff meeting they were 'aiming for a hotel experience'.

Although most people ate in the dining room we observed people in their own rooms were not assisted or encouraged to eat. One person who had been asleep all morning had their lunch left in front of them which remained untouched fifteen minutes later when their pudding was placed alongside it. Both remained un-eaten a further fifteen minutes later. A further three people in the unit for people with dementia had meals placed in front of them but none made any effort to eat it. No staff attempted to assist or encourage people to eat and one staff member was overheard saying to another, people had not eaten, rather than try and encourage them. We observed three drinks left untouched on one person's bedside cabinet which meant they had not been supported to maintain good hydration levels.

One person told us "They (the staff) know what they are doing." They said they preferred to stay in their room but went to the dining room for dinner, adding. "I am able to go and get hot drinks when I want one" and we did observe them doing so in the afternoon.

People who were deemed to be at nutritional risk had food and fluid logs in place. We saw one person's recorded at 08:11 two cups of tea with sugar, 08:29 they had had two pieces of toast and porridge, and 10:25 one cup of tea with sugar. This information was then transferred centrally to enable analysis of each person's intake for that particular day and ensure there were no further risks to be considered. People's weight was also noted on a graph to indicate trends and again pre-empt action if needed such as requesting dietician support.

Two staff members spoke with us about their induction. One who had started within the past six months was able to link what they had covered with the Care Standards which are a set of minimum standards all care workers new to care should be able to reach. This included covering topics such as mental capacity and DoLS, first aid, person-centred care and nutrition. They had also received an on site induction with the

registered manager which covered the care plans and other documentation. We saw a comprehensive induction booklet in some people's files but these were not always completed in a timely manner.

One staff member said they had supervision every eight weeks and a yearly appraisal. We saw evidence in staff files of face to face supervision sessions which included comments by both employee and manager as to their respective views on performance and training needs. Checks were made on staff member's understanding around safeguarding, whistleblowing, DoLS and health and safety amongst other areas. This focus on positive feedback was also reflected in the annual appraisals which we saw. There was also evidence of specific topics being discussed with certain members of staff such as medication procedures with the senior care staff to ensure all had the same understanding.

One staff member told us they had received training in key areas such as "moving and handling, first aid, fire safety, oral care and safeguarding." Another staff member said training was delivered annually, some by e-learning and other areas were face to face such as First Aid. Medicine competencies were checked every supervision. We saw in the policies and procedures file all staff had signed to say they had read and understood the various documents, and most of these were dated November and December 2016 which showed staff had current knowledge. The training matrix showed all staff training was current and the registered manager showed where training was due to expire arrangements had been made for staff to attend renewal sessions. Our discussions with staff about falls management, nutrition and hydration and emergency procedures showed all staff were very knowledgeable and confident in how to approach different situations.

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.

We saw mental capacity assessments were in place although not always completed correctly. One referred to the decision to be made as 'dementia' which was not correct, and another referred to supporting a person with their personal care but had not evidenced who they had made this decision with. We spoke with the registered manager about this and they agreed to check all capacity assessments. Staff, however, understood the significance of obtaining consent and working in people's best interests and we saw this in the interactions we observed. For people with more complex behavioural support needs a range of professionals were involved in their care, providing guidance for staff around medication and techniques to manage such concerns.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The home had six authorised DoLS in place and a further 31 applications had been submitted. The registered manager agreed to chase the local authority to gauge the progress of these applications. Staff were able to tell us who had a DoLS in place and their significance.

We found rooms were decorated with people's personal effects including photographs and some people had their own snacks such as fruit. People had chosen their own door colour. Bathrooms were also pleasantly decorated with appropriate pictures on the wall promoting a feeling of calm and relaxation. Walls had stencils on them with famous actors and musicians with their particular phrases to promote dialogue

and memories. Corridors also contained side tables complete with ornaments also encouraging the feeling of home.

Each person we asked was happy that a doctor would be called if they needed one. One person said "The doctor seems to be around most days". One relative visiting the home said "They are on the ball getting help such as a doctor."

Good

Is the service caring?

Our findings

All the people we spoke with who lived at Newfield Lodge told us they were well cared for. Comments included "The staff are very good, I can't fault them," "The carers are really nice" and "The girls are lovely." One relative told us "All the staff are very nice and friendly."

We observed care interactions which were kind, attentive, caring and compassionate. Staff listened to what people had to say, gave good eye contact and showed patience. We overheard one person asking for staff to help them call their family after lunch and this was duly arranged. People were supported with their mobility and we observed carers holding hands with people to provide a steadying support. One staff member spoke with us about their 'virtual training' in relation to living with a diagnosis of dementia and they said this had really helped them to empathise with people as "I now understand how they must feel."

We heard one carer say to one person "You're looking all sparkly this morning, [name]" which made the person smile. This person was later discreetly supported to the toilet. We observed the carers being pleasant, friendly, cheerful and encouraging. One staff member said "We take people into town and they become different people" as they enjoy it so much. They said "I enjoy this job so much because of spending time with people." Staff were very attentive, especially in the use of walking aids. We observed one person leave the toilet without their frame but a member of staff promptly retrieved it for them. This showed staff knew people's needs and were also sensitive to the risk of falls if equipment was not used.

People were well presented with clean clothes and looked well kempt. Sone of the female residents had painted nails. People were spoken with at every opportunity by staff, whether they were eating their lunch where staff sought their views of the food or if passing them as they walked to assist another person. This acknowledgement helped promote a sense of wellbeing and people being valued.

We observed staff knocking on doors and saying who they were before they entered people's rooms. One staff member told us "I always cover people when helping with intimate care, and ensure their curtains are shut." Another staff member said "We always ask if people want a shave. We encourage them to do it themselves." People's cultural and spiritual needs were considered and one person told us "The priest comes to see me."

The home had members of staff assigned to particular roles known as champions who had a specialist focus. These were to ensure all staff had someone to learn from about specific areas such as safeguarding, medication, health and safety, activities, dignity, palliative care, skin integrity and dementia care.

No one in the home had an advocate as all had family or friends to support them if needed.

Good

Is the service responsive?

Our findings

One person said told us "We can go out as long as you let them know, and sign out and sign back in" and "We all have our own TV so I can watch what I want". Others told us "As well as entertainment and bingo, we have arts and crafts," "There is always something going on" and "You can go out in the grounds when it is warm." People had access to a hairdresser twice a week who visited the home and used its purpose built salon which we saw in use. We observed one person playing a wooden game of noughts and crosses with a staff member playing alongside them. There was a lot of chatter and general buzz in the lounge areas.

We heard one person was looking forward to a trip to the local garden centre to purchase some tomatoes as they were keen to start growing some in time for summer. They returned later in the day with their seeds and staff provided the compost to aid this. One person told us "Yesterday I was singing with a couple that came in to entertain us" and "We have bingo on a Wednesday." In the afternoon we observed carers helping people to make Easter bonnets and Easter cards while other people were mixing batter as it was Shrove Tuesday. One person told us the staff had found an area of corridor for them to hit practice golf balls as the grass outside was too long and they were very pleased about that.

There was a schedule of activities for the week on a noticeboard including planned trips out, some entertainers, a Chinese 'pop up' restaurant and the café for people living with dementia. In addition there was also evidence of people being asked their views on trips, activities and cleanliness within the home and the findings from these questions were then displayed for everyone to see. Dates for the social committee consisting of people living in the home were advertised for the months ahead. One staff member told us "The activity co-ordinator has brought in fly swatters to bat balloons to keep people fit." The registered manager showed us photographs of events which had taken place over the past few months; the people had requested belly dancers and a small group came into the home to entertain people, and there were also pictures of a drag queen act which again, showed many people enjoying themselves.

People had access to a large range of books and magazines, and also colouring books with pens. There was also a resourced sweet and card shop which the registered manager was hoping would eventually been run by people living in the home. This had been made accessible so people using a wheelchair could access it. In the reception area was a wishing well and each person in the home was encouraged to complete a card detailing a wish and the registered manager said these were regularly reviewed and implemented wherever possible.

The home was piloting a move towards electronic care records which enabled care staff to input information instantly and prompted staff if particular tasks such as medication or positional changes were required. Each staff member had an i-pad which allowed them to access people's records only accessed via a password. These included care plans for personal care, safety and the environment, nutrition, activities, communication, continence needs, mobility, medication, emotional support and sleeping patterns. Staff were also able to access the handover notes for each shift and add to them if a GP had been called, for example and could also log any concerns raised by a person or their family. As staff had the i-pad with them they were able to refer instantly to the records which meant it was better for the person as they could

remain with them while checking their records.

Care records resulted from the initial assessment and were person-centred. They included all key aspects of a person's needs such as communication, lifestyle preferences, emotional support needs, mobility, nutrition skin integrity and medication. Each assessment discussed the present situation for a person, what their needs were and how these were to be met with very specific guidance for staff. The level of support required for people was highlighted according to the activity or decision they were undertaking. In one care record we saw '[Name] can communicate their needs but gets confused when people ask them questions. They may need more assistance making choices that are in their best interest…They sometimes find it easier to make decisions if given a choice of two or more.' On each assessed need the person's risk assessment scores were noted helping staff to see instantly how other aspects of their abilities may impact on their care need.

People's preferences and likes were recorded such as chatting and engaging in activities. This was reinforced with detailed life histories of people referring to their family and work histories. Again, care plans identified where this need was to be supported by staff through encouragement to participate in both group or one-to-one interaction. In one care record we saw '[Name] likes to know what's going on…they can become quite upset if they are not told' which helped staff support this person by keeping their anxiety levels low. In some care notes we saw people's individual characteristics were noted which showed staff knew and understood the person well, and how best to support them. People's health conditions were also noted and guidance for staff given as to how to be aware of recurring issues such as urine or chest infections. There was evidence care plans were completed in conjunction with people as their direct comments were recorded in some. This showed the home was ensuring people were as involved as much as possible in their own care planning.

Daily notes evidenced clear chronological accounts of how people's needs had been met during the day. Entries were completed by all staff involved with care and detailed what help was provided, by whom and when. It was also recorded where a person had refused this help and each entry was logged under the specific care need which meant a clear outline could be seen of all staff support offered, accepted or refused. Where people needed specific equipment this was checked daily and logged on people's records.

All people we spoke with told us visitors can call at any time. One person told us "My son comes to take me out regularly; we go shopping or to his house." People also told us they could stay in their rooms or go to the lounges as they wished. One person said "I tend to stay in my room but I do go to the entertainment, it is usually quite good."

Everyone we spoke with told us they knew what to do if they had a complaint. One person said "I'd tell a carer", another said "I'd go down to the office and speak to them if necessary but I've had no complaints" and a further person told us "I'd go to the office and they would probably tell the head office."

Relatives were equally complimentary. One relative said "We have no complaints, as long as [name] is happy then we are". Another relative told us "It is very efficient, I've no complaints." The registered manager advised us no significant complaints had been received over the past twelve months. When checking the records we saw all complaints were acknowledged and investigated, and a letter of apology sent to the complainant. Where items had gone missing the home recompensed people as a gesture of goodwill and if issues were with staff conduct, there was evidenced this had been actioned with the relevant staff member.

Compliments were displayed in the reception area of the home.

Good

Is the service well-led?

Our findings

One person said "Everybody is good, I'm quite happy and contented." Another told us "I think this home is lovely." One relative told us "I am really pleased with what they do for my [name]". Another relative said "I would feel able to raise any concerns if I had any."

Staff were also equally positive about the home. One staff member said "I love it here. It's a good place to work." Another said "We can always speak to the manager or their deputy. They are very approachable." A further staff member told us "I feel like we meet people's needs here." They said "There have been massive changes and all for the better. People get the support they need and so it works better. It's a homely atmosphere." They told us they would be happy for a member of their own family to live in the home.

Staff meetings were held monthly with specific groups meeting such as the managers, senior carers and carers. Consistent messages were shared between all staff groups showing they were given clear direction and expectations. We saw evidence of good practice being identified and staff thanked, specific guidance given in relation to the new electronic care records which showed the registered manager understood the system well, and conversations between staff about different subjects pertinent to ensuring a high level of care support. We also saw discussions about how to involve people in the home more such as with dusting as the registered manager said "It is their home and many of them enjoy helping." Staff were also advised "You need to encourage activities with people, take them for a walk, get a pack of cards out." We saw this in evidence during our inspection.

One staff member said "The registered manager is brilliant. I feel very supported and they are very passionate about the home. Here we care and show it." A different member of staff told us "[Name] really is fantastic. So supportive. They will help on the floor. They're the best manager I've ever worked for." A further staff member said "If something needs doing it will get done. When the registered manager speaks we listen" which showed a healthy respect for the leadership offered. The registered manager showed they were keen to empower their staff. In discussions within a staff meeting it was noted in the minutes "I need to know that if I'm not here, things will happen…We have come a long way since I started but we need to continue to go forward."

Two visiting health professionals we spoke with told us "This is a very welcoming home. We are always listened to and staff follow our advice." The health professionals explained their role as part of the Vanguard project which is an initiative to prevent unnecessary hospital admission from care homes and how the Vanguard staff were able to access training and other agencies as needed to support care in the home. They felt the home had taken full advantage of these links so people could have a better quality of life.

People's views of the various aspects of home life were requested on a monthly basis. Over the past year people had been asked their views on the laundry, whether they felt their privacy and dignity was respected, activities, care plans, cleanliness and any topics which they wanted to discuss, ensuring the home was responsive to people's views. Satisfaction levels were generally high and indicated people could exert choice and control over what happened to them. 100% of people who responded to the survey regarding

care said they were encouraged to make independent choices and could have a bath or shower when they wanted one. People also said they felt involved in their care planning and were treated with dignity and respect. Where issues had been noted there was evidence these had been followed up and checked in action plans which the registered manager completed.

Resident meeting minutes were displayed on the suggestions and comments board which indicated two people had enjoyed the recent Greek 'pop up' restaurant and wished to have trips to the local garden centre. Plans were discussed for a beauty therapist to visit the home for Mother's Day.

We saw evidence of robust auditing procedures in place. Audits included health and safety which had achieved an internal rating of 94% based on the condition of the external of the premises, the use of protective personal equipment, bed rails including evidence of best interest discussions, safeguarding, and the position of the call bell. Similar audits were conducted for infection control, catering and medication. The catering audit had shown a need to develop the dining experience and we saw this in action on the day we inspected for people in the communal areas.

Weight loss for people was analysed monthly including noting what action had been taken where concerns were logged. Each person's actual weight and the amount of loss noted along with a brief synopsis of what other health issues may have impacted on the person. This level of detail showed the home had sound knowledge of people's health and wellbeing. This was also evident in the home's monitoring of people with pressure sores.

Following the previous inspection an action plan had been generated and this had evolved as actions were completed and others needing attention were identified. This ongoing document meant the home was continually seeking to ensure best practice and was not complacent once tasks had been completed.

The registered provider conducted internal compliance visits following the same criteria used in a CQC inspection. This provided specific detail about how the service was safe, effective, caring, responsive and well led, and noted areas for further development. All areas of the service were looked at including accidents, audits, medication and general observations from walking around the home, discussions with staff and each area of progress was checked against the action plan. As ratings were given, these provided an incentive and goal for staff to aim higher.

We asked the registered manager what they felt the values of the home were. They said "To respect all people's needs and choices, promoting independence and offering the best care." They said "We learn from audits and risk assessments, listen to staff and if they're happy, this impacts on good care being delivered." They said they shared good practice through "The promotion of the recommend an employee scheme which encouraged staff to perform well in their roles, identifying sound care delivery through supervision and by saying thank you to staff regularly." They also said as they did regular walks around the home they spoke with staff, commending where things were done well and pointing out areas for improvement.

The registered manager told us they felt supported in their role through the six-weekly visits of the Head of Compliance for the registered provider. They told us they found these visits useful as they saw things which the registered manager could become oblivious to as they were in the home every day. They also received support from their regional director who was responsive to anything that was needed in the way of resources and also kept in touch and supported the registered manager is their day to day role.

We asked the registered manager what they felt the key risks to the service were and they said "Ensuring we meet all our requirements and provide a quality service. However, I do not think we have any weak links at

the moment." They shared their achievements as "Increasing staff morale which had been very low when I first started, increasing involvement with the residents and relatives and the links we have developed with the Vanguard team." They felt this last link had been particularly fruitful in ensuring people had access to the best all–round care. The registered manager was also pleased with the developments with activities which had grown around people's preferences rather than what the staff wished to do. The home had been nominated for the Great British Care Awards and the home's chef had won the Care Home Cook/Chef Award for 2016.