HC-One Limited

# Victoria Mews

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

We carried out an inspection of Victoria Mews on 12 April 2016. The inspection was unannounced.

Victoria Mews provides accommodation with personal care for up to 30 people. There were 26 people living in the home at the time of our inspection. All of the people were living with dementia.

There was a registered manager in post. 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.

The service was last inspected on 18 and 19 August 2015 when we found the provider was not meeting the required standards. We identified one breach in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to improve staffing arrangements and their procedures for safeguarding people from risks and abuse. We asked them to take the necessary steps to ensure the required improvements were made.

The provider sent us an action plan which stated all the required improvements would be completed by 31 January 2016. During this inspection we checked improvements had been made. We found overall improvements had been made and sufficient action had been taken in response to the breach in regulations.

People told us they felt safe living at the home and we saw enough staff on duty to keep people safe. Since the last inspection staffing arrangements had been reviewed and changes had been made to ensure there were enough suitable staff to meet people's needs.

Risk assessments and management plans were in place to minimise the risks to people's safety. However, guidance for staff to follow to manage risks was not always in place. Therefore, we could not be sure people were always being kept safe.

People received their medicines as prescribed and medicines were stored safely. Since the last inspection the administration of topical medications (medicines applied directly to the skin) had been reviewed and improved.

Since the last inspection care staff had completed further training in manual handling to help them carry out their roles safely and effectively. New staff received an induction prior to working unsupervised and staff received training in health and social care to develop their skills further.

Recruitment checks were carried out prior to staff starting work at the home to make sure they were suitable for employment.

The registered manager understood their responsibilities in relation to the Mental Capacity Act (2005). Since the last inspection capacity assessments had been completed for those people who lacked capacity, so decisions could be made in their best interests. The correct action had been taken for restrictions in people's care to be authorised. Staff understood their responsibility to seek people's consent before they delivered care.

People told us they enjoyed the food and said they were able to have drinks and snacks throughout the day. Since our last inspection processes to monitor the food and fluid intake of people at risk of dehydration or malnutrition had improved. However, further improvement was required to ensure the records were completed correctly.

There had been significant improvements to the environment and social activities since our last inspection. This had a positive effect on people and was now more suited to people living with dementia.

People and their families were positive about the care being provided, and knew how to make a complaint.

Care plans were in place and contained more detailed information about people since the last inspection. Care staff we spoke to did have a good understanding of people's care and support needs however, further improvement was required in this area.

Both the provider and registered manager were committed to making on-going improvements to ensure people received care and support that met their needs and preferences.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Staff had a good understanding of how to manage the risks associated with people's care. However, risks were not always accurately reflected in people's records to ensure a consistent approach to the management of risks. People told us they felt safe and staff were available at the times people needed them. Medicines were stored safely and people received these as prescribed.

### Is the service effective?

**Good**

The service was effective.

Staff were supported to develop their knowledge and skills to meet people's needs. New staff received a thorough induction which supported them in meeting the individual needs of people. People were provided with a wide variety of food which they enjoyed. People were referred to healthcare professionals when required. The registered manager understood their responsibilities in relation to the Mental Capacity Act (2005) and where people lacked capacity to make decisions, actions were being taken to ensure they were appropriately supported.

### Is the service caring?

**Good**

The service was caring.

People and relatives were positive in their comments about staff .Staff were caring in their approach and interacted well with people. There were positive relationships between the people living in the home and the staff supporting them. People's privacy was respected and staff promoted people's independence and dignity.

### Is the service responsive?

**Good**

The service was responsive.

Care plans provided adequate information about people's

preferred routines, likes and dislikes and action was being taken for further improvements to ensure more specific information about the support staff were required to provide was included. People's care needs were assessed to ensure they received care and support based on their needs and preferences. The environment provided sensory stimulation to promote engagement for people living with dementia. People knew how to make a complaint and the registered manager dealt promptly with any concerns they received.

## Is the service well-led?

Good

The service was well-led.

There was clear leadership of the service in place. People and the staff spoke positively about the provider's management team. Systems and processes ensured people and staff were involved in decisions related to the quality of service provided. People, visitors and staff were encouraged to give feedback about the quality of service within the home. Audits and checks were completed to ensure the service was under constant review so that improvements were made for the benefit of people who lived there.

# Victoria Mews

**Detailed findings**

## Background to this inspection

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

This inspection took place on 12 April 2016 and was unannounced. This inspection was undertaken to follow up on a previously identified breach, to make sure the required improvements had been undertaken.

The inspection was carried out by two inspectors.

We reviewed the information we held about the home. We looked at information received from agencies involved in people's care and spoke with the local authority commissioning team. Commissioners are people who contract services, and monitor the care and support when services are paid for by the local authority. Commissioners told us they had visited in April 2016 and had been monitoring progress against an action plan that was being implemented at the home.

We analysed information on statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. These can include safeguarding referrals, notifications of deaths, accidents and serious injuries. We considered this information when planning our inspection of the home.

We looked at four care plans and other care documentation such as people's risk assessments, food and fluid charts, medication records and behavioural charts. We looked at the complaints information, staff training records, accidents and incident records and quality monitoring information.

We spent time observing how staff interacted with people in the home. We also used the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experience of people who were not able to talk with us. We also completed observations during the day, including mealtimes in the dining room and the lounges to see what people's experiences of

the home were like.

We spoke with five people who used the service, four relatives and ten staff members including the provider's assistant operations director and the registered manager.

Requires Improvement

# Is the service safe?

## Our findings

During our last inspection on 18 and 19 August 2015 we identified people's risk management plans were not always followed and any behaviour that people who lived at the home exhibited was not always managed well. This was because a number of staff were working at the home on a temporary basis and therefore did not have a good understanding of people's care and support needs.

This was a breach of regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Following the inspection in August 2015 the provider sent us an action plan outlining how they would ensure behavioural risks were being managed well and how they would make improvements to their staffing arrangements. They told us discussions would be held with staff to remind them of the importance of supporting people safely when they showed behaviours that were challenging towards others. The action plan stated that the registered manager would undertake and document observations of staff practices to check risks associated with people's behaviour were being managed well. Training would also be provided to the staff team to further develop their knowledge and skills in this area.

The action plan stated that staff rotas would be reviewed to ensure staff with sufficient knowledge and skills were available to support people. This included how improvements would be made in relation to staff rostering and cover arrangements for staff annual leave.

At this visit we saw improvements had been made. The registered manager explained how staff supported people whose behaviours could be challenging towards others when they became anxious. They said, "We have behavioural policies and ABC charts. It is about identifying the signs and symptoms of what occurred. It also helps with evidence when talking to GPs and deciding what interventions would be useful." (An ABC chart is an observational tool that records information about a particular behaviour. The aim of using an ABC chart is to better understand what the person is trying to communicate.)

A staff member told us the home was calmer now than when we last visited. They said, "It has calmed down a bit, we care for people with complex behaviours but now we have the ABC charts and we speak to people's families so we can see what interventions we need to use." We observed the atmosphere was calm and friendly at this visit.

We looked at a sample of ABC charts and found that the vast majority of these had been completed correctly. However, we saw one chart had not been completed correctly as an evaluation of an incident which took place in January 2016 had not been recorded. This related to a person who had become anxious and a minor injury to a member of staff had occurred as a result of this. We discussed this with the registered manager who told us staff had completed training on how to successfully complete the charts and this was a one off occurrence.

We found improvements had been made in relation to staff being available at the times people needed them. People and their relatives told us they felt there were enough staff to keep people safe. A relative said, "There is always staff in the day rooms when I have been here and I visit at different times." Another explained they felt confident their family member was safe. They told us, "There are control keypads on every door. [Person] needs a safe environment. [Person] knows how to use the call bell in her room to summon assistance. [Person] kept falling over at home and she doesn't fall over as much here."

We discussed staffing levels with the registered manager who told us there were no current care staff vacancies and the use of agency staff had been significantly reduced since our last visit. They explained one senior care worker and four care workers were on duty in the mornings, one senior carer and four care workers were on duty during the afternoon and evening. At night time one senior care worker and two care workers were on duty. They told us the provider staffed the home to 10% above their assessed levels to ensure people were kept safe.

To supplement the permanent staff team 'bank staff' were employed. These staff members provided cover for planned and unplanned shortfalls in staffing and staff absences. This meant people were supported by staff who knew them well. On the day of our visit there was enough staff available to provide the support people needed.

We asked staff whether the improvements made to the staffing had been sustained. We received mixed feedback. Comments included, "Things are more settled now, we use less agency staff so yes, it is better," and, "Sometimes there are only three care workers and one senior care worker on duty in the morning. It makes us feel stressed because we have got the same level of care to give. Depending on who is on duty we can manage well. People still get their needs met but someone can't always be in the lounge." We reviewed staff rotas for the four weeks prior to our visit. These records were consistent with what the registered manager had told us.

Procedures were in place to protect people from harm. For example, we saw the provider's safeguarding procedure was accessible to people, their visitors and staff. The registered manager and the deputy manager understood their responsibilities to protect people and to report potential safeguarding incidents. Records showed appropriate and timely referrals had been made to the local authority as required.

Staff told us they had completed training in how to keep people safe and would report any concerns to the management team. One staff member we spoke with was not aware what the manager would do with the information, therefore, they may not identify when appropriate action had not been taken so they could escalate it further. However another said, "If the manager didn't do what they were supposed to do, I would speak to head office and the safeguarding team." Another said, "I would report it to the senior care worker who was on duty and if I couldn't find them, I would report it to the manager."

The provider's whistle blowing policy was on display for staff (a whistle blower is a person who raises concerns about wrong doing in their workplace). Staff we spoke with were aware of the policy and told us they were confident to raise concerns. One member of staff explained they would not hesitate to challenge poor practice by other staff, for example, poor manual handling and the way staff talked to people. They said, "I would speak to them, explain what they were doing was wrong and report it to the manager."

Staff we spoke with were knowledgeable about the risks associated with people's care. We saw one person became upset. They explained if the person was not reassured their anxiety levels could increase. This could result in them causing themselves harm because they walked around the home at a fast pace when they were anxious and they could trip over. We saw a care worker offered the person reassurance and stroked

their hand which the person responded well to. The care worker then supported the person to go to their bedroom. They told us, "When [Person] becomes upset we know they are tired. We try and encourage them to have a lie down so they can rest."

Overall risks associated with people's care had been assessed and were identified in risk assessments. However, we identified it was not clear how some were to be managed. For example, one person was at risk of choking. Their risk assessment advised staff to 'Be aware [Person] may put small objects into their mouth and they could choke'. There was no information for staff to follow to reduce the risk or guidance on how they needed to support the person to keep them safe. We discussed this with the registered manager who told us they would review this person's risk assessment immediately and add more detailed information.

Recruitment procedures ensured potential new staff members were subject to checks to ensure they were of good character and suitable to work at the home. Records confirmed these checks were in place before they started work. They included a Disclosure and Barring Service (DBS) check and written references. The DBS assists employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with people who use services.

During our last inspection we found the management of topical medicines applied directly to the skin required improvement. During this inspection we recognised improvements had been made. Staff had received further training and topical medications were stored in a locked medication trolley. Staff applied these medications as prescribed and signed a MAR (Medication administration record) to show this had been administered.

We observed a medication round and also reviewed four people's medicine records to check medicines were being managed safely. We saw staff followed good practice. For example, they took medicines to people, provided them with a drink and watched them take their medicine before returning to sign the MAR to confirm they had taken it. The staff member locked the medicines trolley when they left it to give people medicine so there was no risk these were accessible to people.

However, we observed the morning medication round took a long time to complete. The round had commenced when we arrived at the home at 9.30am and was still continuing at 11.40am. We discussed this with the staff member because we were concerned if people required medicines at lunch time there could have been an insufficient time gap between medication doses being administered. This was a potential risk to a people's health. The staff member explained they had started the round later than usual. They said, "If someone needs assistance, I can't just say no." We bought this to the attention of the registered manager who explained how they ensured there was a sufficient gap between people's morning and lunchtime medicines being administered. For example, if people required medicines at lunch time their morning medications were administered at the beginning of the morning round to ensure the gap between doses was sufficient. They told us they would discuss the length of time the round had taken with the staff member to make improvements.

Staff who administered medicines had received training and their competency had been assessed by the registered manager. A series of regular checks and audits took place so if any errors were identified prompt action could be taken.

There were processes to keep people safe in the event of an emergency. We saw equipment that would be needed in an emergency situation was accessible to the staff team. People had personal fire evacuation plans so staff and the emergency services knew people's different mobility needs and what support and equipment they would require to evacuate the building safely. A service contingency procedure was in

place. Therefore, if there was disruption within the home due to an unexpected event people received continuity of care.

Records showed accidents and incidents had been reported to the registered manager when they had occurred. One care worker told us, "If an accident happened I need to report it straight away." Accidents and incidents were reviewed by the registered manager who took action to reduce the risk of them happening again. For example, analysis of the falls that had occurred in the home took place each month to identify any patterns or trends. It had been identified that one person had fallen several times during the night. A referral to the falls clinic was made to seek guidance on how to reduce the number of falls. Two hourly checks had been implemented and a falls sensor had been purchased. This meant if the person fell again staff would be alerted immediately by the falls sensor and they could check if the person was safe.

Checks of the equipment in use at the home took place to ensure it was safe for people to use. A maintenance person worked at the home to undertake general repairs and complete the checks. For example, on the day of the visit the fire alarms were tested to make sure they were working correctly.

Good

# Is the service effective?

## Our findings

People and their relatives told us staff had the skills and knowledge to care for them effectively. They told us, "It's all good, we haven't found any fault in any aspect of care."

During our last inspection we identified staff were not always putting their training into practice. At this inspection we found improvements had been made and all staff had undertaken further training about manual handling to ensure techniques were used safely. For example, we observed two care workers safely transfer a person from a chair to a wheelchair using a hoist.

Records showed care staff had completed training the provider considered essential to meet the care and support needs of people who lived at the home. A training schedule identified when staff had completed training and when it was next due. This helped the registered manager prioritise and plan training the staff needed.

The learning and development facilitator for the home told us, "Training statistics are really good here, as an organisation we aim for 85% compliance. The staff team here have achieved 90%." They explained training was completed either electronically or face to face with staff. One member of staff said, "All of my training is up to date."

New staff members received effective support when they first started working at the home. One new member of staff confirmed they had completed an induction and said, "I completed my training. I shadowed colleagues for two weeks. Once I had seen how they assisted people, I felt confident."

The registered manager explained the induction process for new staff and said, "There is a 12 week induction process which is mapped to the Care Certificate. (The Care Certificate is an identified set of standards for health and social care workers. It sets the standard for the skills, knowledge, values and behaviours expected). New employees are assigned a 'buddy', complete training, and work alongside experienced colleagues. There is a training book they work through which lists the policies and procedures." This process ensured staff were competent in their role and understood their responsibilities in line with the provider's policies.

Since our last inspection the frequency of meetings that took place with staff to discuss their performance at work had increased. The registered manager told us, "Meetings with staff have been increased and things are going well. It gives me an understanding of how staff are feeling and performing." Records showed and staff confirmed their work practices were monitored through meetings and observational checks on their practice.

Staff had completed, or were working towards level two or three qualifications in health and social care. This meant staff had the right skills and knowledge to provide effective care and support to people. We spoke with the deputy manager who described the training he had received as, "Brilliant". He explained he was currently completing a level 5 qualification in health and social care and the provider encouraged him to

further develop his knowledge and skills.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Act requires that where possible people make their own decisions and are helped to do so when needed. When people lack capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the provider was working within these principles and we saw improvements had been made since our last visit. For example, capacity assessments had been completed for those people who lacked capacity, so decisions could be made in their best interests. The registered manager understood their responsibilities in relation to the MCA. They explained how they had submitted applications for people who lived in the home because their freedom of movement had been restricted in their best interest.

We observed people being supported and making daily choices during the visit. We saw staff asked people for their consent before providing assistance. For example, one care worker asked someone, "Is it alright if I trim your nails?" This showed us they understood the principles of the MCA and knew they could only provide care and support to people who had given their consent.

During our last inspection we found records did not reflect when people were refusing assistance with their personal care. This had a potential effect on people's health and wellbeing as they did not have the capacity to understand the consequences of refusing. During this visit we saw improvements had been made and records reflected what assistance had been provided to people.

We asked one care worker what they would do if a person refused assistance with their personal care. They told us, "I would encourage them and try to find out why they didn't want me to help them but I can't force them. I would ask another member of staff to see if they could help and I would report it if they continued to refuse."

People we spoke with told us they were satisfied with the food served in the home. They told us, "The food is nice." One person's relative said, "I have visited at lunchtime and the meals seem excellent." People were encouraged to eat a healthy balanced diet and had a choice of food and drink that met their dietary needs.

We observed the mealtime experience in the dining room. There were two choices and both options were plated and shown to people to assist them in making their choice, which was supportive of people living with dementia. However, we observed not all staff were offering people meal choices in this way. A care worker later confirmed they were supposed to offer people choices in this way but it did not always happen. We discussed this with the registered manager who told us they would discuss this with the staff make improvements.

We saw some people were seated at dining tables for 30 minutes before they were served their meal. One person became anxious and left the table several times whilst they waited. The person was reassured by care staff that their meal was on its way and the person responded well to this. Staff explained the reason for the delay and assured us people did not usually have to wait for their meals to be served.

Meals were nicely presented and staff were available to assist people if they needed support. People had been provided with adapted cutlery and plate guards to help them eat their meals independently. People were asked if they needed assistance cutting up their food. However, we saw a care worker poured gravy onto one person's meal without first asking the person. Another care worker shouted across the dining

room, "Has [Person] got a bib." This was not dignified or respectful towards the person. We discussed what we had seen with the registered manager who told us they would discuss this with care staff and observe lunchtime the next day to improve the experience for people.

Staff we spoke with demonstrated a good knowledge of people's nutritional needs. For example, care workers knew who needed encouragement to eat and who had been identified as being at risk of losing weight. We saw these people were offered fortified drinks during our visit which included milkshakes and hot chocolate with whipped cream. (Fortified foods are foods to which extra nutrients have been added).

Where people needed to receive a specific amount of food or fluid to maintain their health their daily intake was monitored by staff using a chart system. The completion of these charts had improved since our last visit however, further improvement was required. We could not be certain people had received sufficient nutritional intake as accurate quantities being consumed were not being recorded. For example, 'Pudding' or 'Dinner, ate all,' was written but the quantity was not recorded. The registered manager told us all staff had completed training on how the charts should be completed and this would be discussed with staff to ensure the charts were completed accurately in the future.

People told us they had enough to eat and drink. Records showed staff were totalling the fluids people had consumed at the end of each day to identify when people may require prompting to drink more. This was an improvement as during our last visit this had not been happening.

Where changes in people's health were identified they were referred to the relevant healthcare professionals including their GP. One person told us, "The doctor and the nurses do visit." People's records showed how the home worked in partnership and maintained links with health professionals. This meant people who lived at the home received the appropriate health care to meet their needs.

Good

# Is the service caring?

## Our findings

People and their relatives provided positive feedback about the staff. Comments included, "They (staff) work really hard. They do a good job and they do it because they care," and, "They are very caring staff. They have always got time for you."

During our last visit we found interaction from staff towards people focussed on when they offered support or completed a care task. During this inspection we found that improvements had been made. We saw people were treated with kindness and positive interactions took place. For example, we spent time in communal areas and observed staff had the time to sit and chat with people. We saw staff knelt down to talk with people so they were on the same level as them and people responded well to this and engaged in conversations.

Staff knew what support provided comfort to people and we saw appropriate distraction techniques were used when people became anxious. For example, we saw a care worker comforted a person by stroking their hand. The care worker told us, "Just stoking their hand can reduce their anxieties; I do it because I care about them."

All the staff we spoke with showed concern for people's wellbeing. This included staff who were not directly involved in providing care to people. For example, the maintenance person greeted one person in the corridor and said, "Take your time don't rush."

Positive relationships had formed between some people who lived at the home. We saw two ladies enjoyed a friendly chat whilst they had a cup of coffee and shared a packet of biscuits. They told us, "We get on well; we enjoy each other's company and like having a chat."

People were encouraged to maintain relationships important to them. Relatives were encouraged to be involved in their family member's care and there were no restrictions on visiting times. One relative told us, "It is an open door policy so I can come to visit whenever I want. It is nice to come in at any time because you can actually see what is going on." Another said, "I am invited to stay for lunch on Sundays." They explained this made them feel welcomed.

Since out last visit, staff had undertaken further training in meeting the needs of people with dementia and how to promote their privacy and dignity. The deputy manager told us he was completing a training course to become a 'Dignity Champion' at the home. The purpose of this was to gain a greater understanding of how people's dignity was being maintained and to make best practice recommendations to staff to benefit people living at the home.

One person's relative told us, "They [care staff] always treat everybody with courtesy and respect." We saw this happened. For example, one person who lived at the home preferred to be called by another name rather than their first name. Staff respected this and addressed the person in their preferred way. This was reflected in the person's care plan.

Another relative explained to us how care staff encouraged people to maintain their independence. They said, "They encourage people to get up and have a walk around to stay mobile rather than use a wheelchair even though this can take a long time as some people walk slowly." They told us this made them feel reassured that staff were caring as they gave people enough time to complete tasks.

During this visit we noticed that clocks and calendars were maintained to ensure they showed the correct date and time to promote people's independence. This was supportive to people living with dementia and was not happening during our last visit. The activities co-ordinator explained the night staff changed the date and this was done consistently every day.

We saw staff knocked people's bedroom doors and waited for permission before they entered. This showed they resected people's right to privacy. A relative told us, "If the staff know we are here they will close that door so we can have a private visit."

People were offered choices and care staff asked people where they wanted to spend their time. We observed people did choose to spend time in different areas of the home through the day.

The registered manager told us people had been involved in making some of the decisions about how the environment had been improved since our last visit. For example, we saw framed pictures which people at the home had created were on display. The pictures were supportive for people who lived with dementia as they were old photographs of the local area. One person told us they remembered the local bus station and town hall and they enjoyed looking at the pictures because it was their "memories." The person smiled and explained they had got married at the town hall.

Information about a local advocacy service was on display in the home. The registered manager told us no one at the home currently used the services of an advocate however they had in the past and this was available to support people if required. An advocate is a person who supports people to express their wishes and weigh up the options available to them, to help them to make a decision.

During our last visit we saw daily records were kept in cupboards in the communal lounge areas. During this visit improvements had been made as this information was stored in locked cupboards to ensure people's confidential information was not accessible for others to view.

Good

# Is the service responsive?

## Our findings

People and their relatives told us staff were attentive and responsive to their needs. One relative said, "If mum needs something, they [staff] do it willingly, nothing is too much trouble."

Care staff we spoke with were responsive to people's support needs. For example, they told us one person liked to get up between 8am and 11am each day. They told us as soon as the person woke they liked to get up and dressed but they were unable to use their call bell to summon assistance. They explained if support was not provided promptly the person could become anxious. Therefore, staff checked the person frequently between these times to make sure they provided support when the person required it.

Care workers knew people well. For example, we saw a care worker switch on a radio in a communal lounge. After a few minutes three people started tapping their foot on the floor along to the beat of the music and one person started to sing along when a Beatles song stated to play. The care worker told us, "I know how much people enjoy listening to music especially songs from the 1960's."

There was a photo board of staff in the entrance hall so people and visitors to the home knew the staff who worked there. A relative said, "This is a good thing, we see the same familiar faces and we know who the staff are."

We looked at a selection of care plans which provided adequate information about people's preferred routines, likes and dislikes. However, we saw there were inconsistencies in the level of information recorded and it was not always clear what specific support staff needed to provide to people. For example, one person frequently took off their shoes and walked around the home with bare feet. Their care plan advised staff to 'Support [person] when they did this'. We discussed this with the registered manager and they acknowledged more detailed information needed to be added. They explained work was on-going to improve care records and compile new care plans. This was to help staff to provide more person centred care in accordance with people's wishes and preferences.

People's relatives told us they were involved in care planning and reviews took place approximately every six months. One relative told us, "If I'm at home and they [staff] think I need to know something they phone me. They don't just make decisions." They told us this made them feel involved and informed about their relative's well-being.

Prior to admission to the home, people were assessed to determine their level of independence and care needs. The deputy manager explained this process was important as it made sure the home was the right place for the person to live and to ensure people's needs could be met. One person's relative told us this had happened before their mother moved into the home. They said, "The deputy manager came and asked me and mum questions. It was very professionally done. They came to my house and asked about her likes, dislikes and routines. They explained to Mum what would happen when she moved in."

A keyworker system was in place. This meant people were supported consistently by named care workers.

One member of staff said, "I am a keyworker to a few people; I make sure they have all of the toiletries that they need. I know them and their families well."

During our last visit we found limited activities took place for people to enjoy. We saw improvements had been made and there was more stimulation for people living with dementia. A notice board in the entrance hall displayed upcoming events which included a magic show and a St George's Day picnic which people's relatives and friends had been invited to attend.

A variety of activities which were specific for people living with dementia took place on the day of our visit. For example, we saw people were involved in a ball game. The ball had questions written on it and when someone caught the ball they were asked a question. Several people were keen to participate and this generated discussion and laughter around the room. One person said, "I love this game." A person's relative commented, "The game is a great and simple idea, it gets people talking to each other."

We spoke with the activities co-ordinator and they told us how they had improved the activities for people who lived at the home since our last visit. They told us, "I ask people what they would like to do and I organise it." They explained to us how they planned and evaluated activities once they had taken place. If people enjoyed the activity it was organised again.

Since our last visit the provider had made further improvements to the environment to provide more stimulation for people living with dementia. For example, a sensory area with colour changing light bulbs was available to people. Staff told us this was beneficial to some people's well-being as they liked to sit and relax whilst watching the lights change colour.

The registered manger told us people had been involved in improving the environment. For example, people had chosen to have an 'underwater' theme in one of the corridors. Brightly coloured pictures of fish were attached with Velcro to display boards. We saw several people who walked past touched and moved the fish around. One person told us, "It's like the sea, the fish live there." People had also requested that a mini bus was purchased so they could go on more day trips. We saw this had happened and day trips to Skegness and Blackpool were being arranged for later on in the year.

We saw 'rummage cupboards' were accessible to people. They were filled with items which interested people for example, small musical instruments and textured balls. Tactile objects for people to touch including locks and bolts and hats hanging on hooks were located throughout the home. During our visit we saw people unlocking the bolts and touching the hats which showed us people's senses were stimulated by the items.

Staff told us how they supported people to make choices. For example, they held up two jumpers and the person choose which one they would prefer to wear. This meant that staff were supporting people to make choices and communicating in a way people understood.

Handover meetings took place at the beginning of each shift as the staff on duty changed. The health and well-being of each person living in the home was discussed and changes were communicated. A 'flash meeting' also took place each day. During the meeting the heads of department within the home discussed issues and shared information about the service. We attended this meeting during our visit and saw this happened. For example, the senior care worker shared that one person seemed anxious and unsettled. Therefore, the person required additional support from care staff. These meetings helped staff to ensure people received the care and support they needed to meet their needs.

All people and relatives we spoke with felt they could go to the registered manager with concerns and that they would be acted upon. One person' relative told us, "We have no complaints, if [registered manager] was here I would talk to her or if she wasn't around I would talk to [deputy manager]." The provider's complaints procedure was displayed in the entrance hall. There was also information about external organisations people could approach if they were not happy with how their complaint had been responded to.

We looked at the complaints file maintained by the registered manager. Three complaints had been received in the last six months about the service provided. The complaints log confirmed the complaints received had been responded to promptly and in accordance with the provider's policy. One complaint had been regarding a staff member using their mobile phone in a communal area whilst on duty and we saw what action the registered manager had taken. Staff meeting minutes showed this had been discussed. All staff had been reminded the use of mobile phones whilst on duty was not acceptable and may result in disciplinary action being taken against them.

Good

# Is the service well-led?

## Our findings

We spoke with people, their visitors and staff about the management of the home. People told us they were happy living at the home and thought it was well-run. One relative told us, "I know who the manager is. She is very pleasant and approachable."

Staff were positive about the management team and told us they enjoyed working at the home. One told us, "The managers help us; we can go to them if we have any problems." They explained they were confident to approach the management team and this made them feel supported.

We asked staff how things had changed in the last eight months. They told us, "The managers have made positive changes. The quality of care has got better. The environment is a nicer place for people living with dementia and overall, the staff are happier."

The provider's management team consisted of a registered manager and a deputy manager. The registered manager was experienced and had been in post for over 12 months. Support was provided to the managers by the provider's assistant operations director. The registered manager told us, "[Assistant operations director] is always available to give me advice. She is really supportive and visits the home at least once a month."

During our last visit we found quality assurance systems were in place, but action had not always been taken to manage issues identified. During this visit we found overall, there had been significant improvements for the benefit of the people who lived at the home.

We asked the registered manager how they had implemented the required improvements. They told us, "We focussed on different topics at monthly staff meetings. I think there is a massive improvement but we all feel there are things we can still make better. We are continually learning. We recognise that we can't sit still and we have to adapt and change as we go along."

Staff we spoke with confirmed monthly staff meetings took place and they were encouraged to contribute items for discussion. One said, "In staff meetings we do try and tackle problems that have been brought up by residents and their families and learn lessons from mistakes we made in the past." We found levels of staff sickness had reduced since out last visit which had improved the continuity and consistency of care. The deputy manager said, "Sickness levels have dropped and staff are committed to providing a good service."

Systems for managing risks associated with people's care had improved and staff had a clearer understanding about how to manage risks and how to keep people safe. However, some records required further review to ensure information about managing risks was clear for staff. The registered manager recognised risk assessments required further improvement and they intended to continue to improve them.

The management team completed regular checks of different aspects of the service. This was to highlight

any issues in the quality of the care provided, and to drive forward improvements. For example, the managers conducted regular checks on cleanliness of the environment and people's medicines.

Senior managers completed monthly quality monitoring visits to the home. The last visit had been completed in April 2016 and records showed no concerns had been identified. The assistant operations director also completed a full audit of the home twice a year. As part of these visits records showed they spoke with staff and visitors and identified good practice and areas that required further development. These checks should ensure the home was run effectively and in line with the provider's procedures.

We spoke with the assistant operations director during the visit and they told us, "The residents come first; the home is a better place than it was six months ago." They explained how they had reflected on our last inspection report. They had developed an improvement action plan with the registered manager to implement necessary changes and monitor the home's progress. We discussed the action that had been taken to manage risks more safely and to ensure enough suitably trained staff were on duty. For example, during our last visit there had been some nights when there was no suitably qualified member of staff on duty to give people their medicines. We saw this had been addressed and a trained senior care worker was on duty to ensure people received their medicines if they required them.

The assistant operations director told us they felt the registered manager and deputy manager worked effectively together and this had made the home more settled for the people who lived there. They told us a new forum for deputy managers had recently been set up. This had been implemented to ensure deputy managers within the organisation felt supported in their roles. This gave them gave them the opportunity to share good practice and gain support from their peers.

Records showed that twice daily 'walk arounds' by managers took place. One member of staff said, "This is a good thing, managers need to see what is happening." The registered manager and deputy manager had a 'hands on approach' and worked alongside care staff on a daily basis. For example, the registered manager made people drinks in the afternoon and the deputy manager served meals to people at lunchtime. This approach along with the daily 'walk arounds' ensured managers had an overview of how staff were providing care and support to people and gave them the opportunity to speak with people and staff.

We saw good team work and communication between the staff team and registered manager during the visit. For example, we saw staff confidently approached the registered manager who provided them with support and advice. We looked at communication processes which included handover records and communication books. This showed that staff could pass on information and receive important messages from the management team.

The registered manager said they were, "Proud of the staff team," and it was "Really important to recognise how hard staff work and make them feel valued." The provider had a process of recognising individual staff member's commitment with 'Kindness in Care' awards. Staff who received the award were presented with a certificate and gift vouchers. Their photograph was displayed on the noticeboard in the entrance hall. We saw staff had recently been nominated by people's relatives and a staff member had been recognised for, 'The greatest kindness and professional behaviour during an awful time, showing great empathy with the family." One member of staff said, "It's good we are recognised, we do work hard." They explained how this had a positive effect on staff morale.

The management team encouraged feedback from people, their relatives, visitors and staff. Annual quality questionnaire were sent out to gather people's views on the service. Completed questionnaires were analysed to assess if action was required to make improvements.

We saw there was a 'Have Your Say' tablet computer in the entrance hall where people could give instant feedback about the quality of care within the home and share any concerns they had. The manager was instantly alerted via an email when any feedback was received. Records showed in the last six months over one hundred positive comments and no negative comments had been received. Comments included, 'Staff are always helpful and accommodating', and 'The home is good but they could do with some new towels as the current ones are looking worn.' The registered manager told us, "It's a great way for people to tell us how we are doing and we listen to people's suggestions." We saw this happened for example, new towels had been purchased.

People and their relatives were invited to attend regular meetings so they could make suggestions about how the home was run. The dates of these meetings were displayed in the entrance hall of the home. We saw meetings were held at different times of the day to give family members more opportunities to attend. The registered manager told us attendance was often low and they had attempted to make the meetings less formal to try and improve this. For example, the last meeting had been combined with a cheese and wine tasting session. They explained this event was popular so they planned to hold this event again in the near future.

The registered manager told us which notifications they were required to send to us so we were able to monitor any changes or issues within the home. We had received the required notifications from them. They understood the importance of us receiving these promptly and of being able to monitor the information about the home.