Signature of Leicester (Operations) Ltd

South Lodge

Inspection report

307 London Road
Leicester
Leicestershire
LE2 3ND

Tel: 01162748000

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 7 June 2016 and was unannounced.

South Lodge is registered to provide nursing and residential care and support for 106 older people with dementia and mental health needs. At the time of our inspection there were 97 people using the service. The home has four floors. The Langton unit is situated on the ground floor and Charnwood and Foxton units on the first and second floors. Beacon Knowle unit is situated on the top floor and specialises for people living with dementia. It has restricted access for the safety of the people living there.

South Lodge had 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.

People felt staff were kind and caring, and their privacy and dignity was respected in the delivery of care and their choice of lifestyle. Most of the relatives we spoke with were also complimentary about the staff and the care offered to their relatives. People were involved in the review of their care plan, and when appropriate were happy for their relatives to be involved. We observed staff offered people everyday choices and respected their decisions. People's care and support needs had been assessed and people were involved in the development of their plan of care. Staff had access to people's care plans and received regular updates about people's care needs.

People were provided with a choice of meals that met their dietary needs. The catering staff were provided with up to date information about people's dietary needs, and constantly sought the opinions of people to tailor their individual meal choices. Medicines were ordered, stored and administered safely and staff were trained to provide the medicines people required. Care plans included the changes to peoples care and treatment, and people attended routine health checks.

There were sufficient activities staff to provide a good level of planned and meaningful person centred activities for people over all seven days of the week. The provider had engaged with national activity providers association (NAPA) to identify appropriate activities and pastimes, and train staff accordingly. Staff had a good understanding of people's care needs. People were able to maintain contact with family and friends as visitors were welcome without undue restrictions. Staff sought medical advice and support from health care professionals.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. They received induction and on-going training for their specific job role, and were able to explain how they kept people safe from abuse. Staff were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse.
There were sufficient staff available to meet people's personal care needs and we saw staff worked in a co-

ordinated manner.□

Staff told us they had access to information about people's care and support needs and what was important to people. Staff knew they could make comments or raise concerns with the management team about the way the service was run and knew these would be acted on.

The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours. The registered manager undertook quality monitoring in the home, which fed into the checks the area manager carried out to keep the board of directors informed on the progress of the home. The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service, their relatives and health and social care professionals. We received positive feedback from visiting professionals with regard to the care offered to people and professionalism of nursing staff. Staff were aware of the reporting procedure for faults and repairs and had access to the maintenance to manage any emergency repairs.

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

Potential risks to people were managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported. People were supported by sufficient numbers of staff to ensure their safety at all times. Medicines were stored and administered safely.

Is the service effective?

Good

Staff were trained and supported to enable them to care for people safely and to an appropriate standard. Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005. People received appropriate food choices that provided a well-balanced diet and met their nutritional needs.

Is the service caring?

Good

Staff were caring and kind and treated people as unique individuals, recognising their privacy and dignity at all times. People were encouraged to make choices and were involved in decisions about their care. Staff gave people reassurance when they needed it.

Is the service responsive?

Good

People received personalised care that met their needs. Staff provided meaningful and person centred activities for the people using the service. These were provided in line with national activity providers association (NAPA) and by staff employed for that purpose. People told us they would have no hesitation in raising concerns or making a formal complaint if or when necessary.

Is the service well-led?

Good

The home had an open and friendly culture. We had mixed comments about the registered manager and others in the management team. People using the service and relatives had opportunities to share their views on the service. The provider used audits to check people were being provided with good care and to make sure records were in place to demonstrate this.

South 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 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 7 June 2016 and was unannounced.

The inspection team consisted of two inspectors, a specialist nurse adviser and an expert by experience. A specialist nurse adviser is a qualified nurse who has experience of working with this service user group. This nurse specialist was a qualified mental health worker, and worked in a number of areas with older people.

Prior to our inspection visit we looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about. We also looked at other information sent to us from people who used the service or the relatives of people who used the service and health and social care professionals.
The provider sent us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted commissioners for health and social care, responsible for funding some of the people that lived at the home and asked them for their views about the service. They told us there were general concerns over the number of thefts in the home, but had no other concerns. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
During our inspection visit we spoke with twelve people who used the service, two family carers and a private carer. A family carer is a person's friend or relative who has continued to care for them following their admission to the home. Private carers are carers employed by the person, a relative or appointed person, to provide care within the setting of the nursing home.
We spoke with the general manager (registered manager), care manager, two nurses, three care staff and a visiting health professional. We reviewed the records of twenty one people and pathway tracked nine people. Pathway tracking is a way of assessing in detail a person's records from their introduction to the

home until the day of our inspection visit.

We looked at four staff recruitment records and repair and maintenance records for the building. We also received some updated information following the visit; this consisted of the staff training matrix, and the minutes of food and beverage meetings.

Good

Is the service safe?

Our findings

People told us that they felt staff cared for them safely. One person told us, "I am happy living here, I am safe living here with everyone else." A relative told us that their family member was safe and well cared for. They stated, "[Person] is safe here because the staff look after her."

Staff were able to tell us about individual people's needs, and the support they required to stay safe. People's care records included risk assessments, which were regularly reviewed and covered areas of activities related to people's health, safety, care and welfare. Care plans and associated risk assessments identified any changes in risks to people's health and wellbeing. The care plans provided clear guidance to staff in respect of mitigating risk. For example, guidance on food intake in response to a choking risk and prescribed numbers of staff and what equipment should be used to mitigate moving and handling risk. People told us they were involved in discussions and decisions about how risks were managed. One person told us that prior to their discharge from hospital, their family had discussed what could be put in place to reduce the impact of their falls from bed. Their risk assessments had been updated to reflect the special padding placed at the side of their bed, and height of the person's bed.

Nursing staff provided a quality service to people with wound care and nursing needs. We reviewed the records of seven people that required specialist dressings and treatment because they were at risk of skin damage. The nursing response was effective and risk assessments were implemented and regularly reviewed. Pressure relieving equipment was in place and turning regimes to relieve pressure had been implemented. Position changes were recorded and in accordance with people's individual care plans. Any marks or changes in people's skin were recorded on body maps. Wounds were photographed and dated and wound care plans were developed and involvement and support from a Tissue Viability Nurse was provided as required.

The provider had a safeguarding policy and procedure in place that informed staff of the action to take if they suspected abuse. Staff we spoke with had received training in safeguarding people from harm and had a good understanding of what abuse was and their responsibilities to act on any concerns they had about people's safety. Staff knew the different types of abuse and how to identify them. Staff were aware of the whistle blowing policy and told us how they could use it if their concerns were not acted on. They also knew which authorities outside the service to report any concerns to if required, which would support and protect people. The registered manager was aware of her responsibilities and ensured safeguarding situations were reported through to us appropriately.

There had been a number of reported thefts from people's bedrooms. The provider arranged for closed circuit television cameras (CCTV) in each corridor. People and their relatives had been informed of these being introduced through meetings and an individual letter to each person living in the home. The registered manager told us the reported thefts had now stopped. All bedrooms had lockable doors and secure storage that allowed people to keep their valuables safe. There was also a facility where people could keep valuable items in the office safe, though the registered manager stated few people had taken this up.

The building was well designed to meet the needs of people with age related conditions and was well-appointed and maintained. The corridors throughout the building were wide, railed and spacious, which allowed people to move around the home unobstructed. The top floor of the home which specialised in helping people live with dementia, was well-designed and safe for people. Access to the lift and stairwells was restricted to ensure people's safety. We saw people moved around the service safely and used the fixed handrails or support from staff. There was safe access to outdoor space on both the ground and fourth floor, where people could access a specially constructed balcony.

In the event of a fire or emergency and if an evacuation was required, personal evacuation plans (PEEP's) were in place, and along with other documents had been transferred onto the electronic care plans. Paper copies of the PEEP's were kept in the reception area of the home. A floor manager showed us the electronic form which was dated and ensured the latest information was available. This was important as the provider had a 'stay put' policy in case of a fire. The building was designed with additional fire prevention equipment such as a sprinkler system, to assist staff in keeping people safe in the event of a fire. Staff told us they took place in periodic fire drills.

Staff told us they believed there was sufficient staff on duty to ensure people were safe. They said there was always staff appointed to be in communal rooms to ensure people's safety. People and their relatives also told us that staffing levels were sufficient to keep them safe. A family carer said, "I have no concerns about my mother's safety with regard to the number of staff there are." A care worker told me, "At times it can be very busy – [sometimes] we don't have a minute." We found staff in sufficient numbers to assist people with their personal needs on all four floors of the home. A visitor said, "I honestly feel the staff do try their best, it's just that they don't have time to just have a chat." A privately paid care worker told us, "They try their best but there are just not enough of them, especially at morning times and mealtimes." However we found there were enough staff throughout the home to provide adequate levels of care and safety.

We saw how the electronic care planning documents were used in calculating the appropriate care staffing levels. On the day of our visit that equated to nine care staff, a senior carer and floor manager for 25 people on Charnwood. There were similar staffing ratios throughout the other floors of the home.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for staff. We found that the relevant background checks had been completed before staff worked at the service.

We looked at the records for 16 people who received medicines. Most of the medicines that were prescribed, were kept in people's bedrooms in a locked cabinet. The medication administration record (MAR) chart was also kept in the person's bedroom. These had people's photographs in place to reduce the risks of medicines being given to the wrong person. The MARs were completed with signatures and countersignatures, where these were required. Information about identified allergies and people's preference on how their medicine was offered, was also included.

Some specialised medicines such as 'as required', (PRN) were stored in a separate room accessible only by the nursing staff. We saw there were protocols to guide staff to the circumstances and regularity when these medicines should be given. The provider undertook regular audits to check that people received their medicines as prescribed. The audits included the monitoring of the temperature medicines were stored at, which were within the appropriate levels, and meant that the medicines remained potent and ready to administer to people.

Good

Is the service effective?

Our findings

One person using the service said "I know staff go on training as one of staff told me that they had just been on one (training course)." Another person told us that staff were trained to meet their needs, and said, "Oh, yes, I have great trust in them." Staff told us they received training on commencing employment with the home.

Staff said there was enough training and they did not feel they had any gaps in their knowledge. There was evidence staff had received training in safeguarding, moving and handling, food and hygiene, fire awareness, health and safety and mental health awareness. Some staff received additional training in infection control and medicine administration. A member of care staff told us that they regularly attended training as well as training upgrades. They mentioned that they had recently attended courses for dementia care, challenging behaviour and avoidance techniques (for personal safety).

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

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Throughout our inspection we saw staff offered people choices and sought consent before they offered assistance.
Where DoLS applications had been made we saw that a general capacity assessment was in place for one out of three applications. However, this had not been completed correctly and so was not decision specific. There was also the facility within this form to complete the best interest's decision.
The form which had been completed had included the person's close relative, and the unit manager told us this relative had a lasting power of attorney (LPA) for finances. That meant people had close relatives involved in their care and their confinement was authorised.

The appropriate deprivation of liberty safeguards (DoLS) had been applied for, to ensure people were lawfully restricted from leaving the Beacon Knowle unit. Where DoLS had been authorised they were current and conditions were being adhered to. There was also a care plan supporting each authorisation. The registered manager had informed the CQC of all the current DoLS that had been granted by the local authority. We saw staff used moving and handling equipment and transported people appropriately by wheelchair. We saw that staff spoke with people in a friendly and compassionate way, and kept them informed of the actions they were about to undertake.

We asked people about the food and got mixed comments from people, one person said, "The food is always very good." However another three people and family member told us they did not enjoy the meals

since the new chef had commenced employment. We spoke with the registered manager about this, and she said there were several ways in which people had suggested changes to the menu. These would continue along with regular meetings by the chef to ascertain people's individual tastes, and these would continue to be added to the menu. We looked at a sample lunch menu which provided people with the choice of three starters, three main courses and a selection of sweets. In addition there was also a 'light bites' menu which offered people a range of lighter meals such as omelettes and salads.
The home had two dining rooms with the daily menu on display outside the ground floor dining room. People had a choice of juice or water to drink while they were waiting for their food to be served. The dining room on Beacon Knowle specifically catered for people living with dementia. We saw some people were still having breakfast at 11.15 which meant people were served meals at a time to suit their individual needs. People who could not make a choice of meals from the written menu, were offered a choice of plated meals. That meant people were prompted visually to make a suitable meal choice. People were offered support to eat their meal in line with their individual needs, and staff offered this in a sympathetic and un-hurried way. A family carer who told us, "The meals are excellent here; at least my relative likes them. She can be a bit slow but they feed her at her pace." A person said, "I like coming down to the dining room for lunch, I sometimes have breakfast and some other meals in my room."

We spoke with the catering staff who told us about the range of diets catered for which included pureed, fortified, and diabetic. We looked at records for four people who needed particular support with their nutrition and hydration. All care files included nutritional assessments and associated eating and drinking care plans. Monthly weights were recorded as part of the Malnutrition Universal Screening Tool (MUST), and people were assessed for specialist help with their diet by a recognised professional. There was evidence in care plans of the use of dietary supplements, fortified meals and the consistency of food was altered to ensure people were provided with an appropriate diet to maintain their health. There were also who required their food made easier for them to swallow, whilst others required a low sugar diet. Staff knew about people's dietary requirements and their care plans were detailed with individual preferences. However these people had a very restricted choice. The chef agreed, and said they were working towards providing appropriately prepared meals with specialised ingredients and a greater choice to those people.

People were offered drinks throughout the day and some people required their fluid intake to be monitored for health reasons. For example some were fortified with cream and some were thickened for people with swallowing difficulties, which meant people were offered drinks appropriate to their needs, and at a frequency to guard against dehydration. There were targets identified for each person and daily amounts were totalled automatically when staff recorded the information within the electronic care plan. We spoke with the registered manager about this who said the electronic care plan had been introduced to the entire home. The system now alerted staff when people had not had adequate fluids, and staff could take steps to alleviate the situation.

We saw a visitor assist a person to the bistro for a morning drink. They made the choice and stayed down for lunch in the restaurant. We spoke with them on their return, as we were aware the person's fluid and food intake was being monitored. The visitor told us, "Well, I tell them exactly what and how much [named person] has but I don't think it is always registered." We checked later and an adequate diet and fluid intake had been recorded by staff. A relative had raised concerns that a person living in the home was unwell and that their food intake was not being recorded. We spoke with a staff member who said, "They have been sleepy today. We went down to lunch and I assisted them. They had a bit of soup, bit of main and all of the pudding. They sometimes will have two puddings but they didn't want that today." We looked at the food record which was completed regularly and the person was eating a varied diet along with supplements recommended by the dietician such as milkshakes and ice cream. The person's weight was recorded monthly and they had experienced a slight increase.

Records showed that people had access to a range of health care professionals including GPs, a specialist dementia team, SALT staff, district nurses, chiropodists, opticians, and dentists. If staff were concerned about people's health they referred them to the appropriate health care services and accompanied them to appointments. That meant that people were supported to maintain a healthy lifestyle.

There was evidence where people's additional health needs had been responded to by staff as they arose. For example referrals to: GP's, Dietician or nutritionist, the Tissue Viability Nurse, Speech and Language Therapist and Community Psychiatric Nurse.

We looked at records for four people who needed particular support with their nutrition and hydration. All care files included nutritional assessments and associated eating and drinking care plans. Monthly weights were recorded as part of the Malnutrition Universal Screening Tool (MUST), and results were routinely recorded. We saw there were assessments of choking risks and referrals to Speech and Language Therapists (SALT) and Dieticians in response to assessed difficulties. There was evidence in care plans of the use of dietary supplements, fortified meals and the consistency of food altered to ensure people were provided with an appropriate diet.

We looked at peoples care plans who required to have their fluid intake monitored for health reasons. There were no targets identified for the peoples' fluid intake, as the forms used did not have a section to record a target intake. We found the daily amounts were either not totalled, or totalled incorrectly, not taking into consideration fluids taken in the evening or through the night. Without clear targets, and daily totals, there is low confidence that fluid intake monitoring is routinely monitored. However, the actual fluid intake provided was adequate. That meant people were having enough to drink but the recording was not accurate. We spoke with the registered manager about his who said an electronic care plan had been introduced to one of the floors, and was being expanded to all of the home on a phased basis. That meant that the forms would automatically total the staff entries, and ensure staff were alerted to people that did not have adequate fluids.

We saw that there were other people living in the service that required a specialised diet. Staff knew about people's dietary requirements and their care plans were detailed with individual preferences. However these people were not catered for appropriately, and had a very restricted choice. The chef agreed, and said they were working towards providing appropriately prepared meals with specialised ingredients and a greater choice to those people. That meant the staff were working towards providing a full choice service for all in the home.

A relative had raised concerns that a person living in the home was unwell and that their food intake was not being recorded. We spoke to a staff member who said, "They have been sleepy today. We went down to lunch and I assisted them. They had a bit of soup, bit of main and all of the pudding. They sometimes will have two puddings but they didn't want that today." We saw that the food chart was completed and the person was eating variable amounts of food. Dietetic advice had been received from March 2014. This was recorded in the care plan and we saw from the food charts that recommended foods such as milkshakes and ice cream were offered. That meant the person's diet was being observed to ensure it met their nutritional needs. The person's weight was recorded monthly and they had experienced a slight increase. That meant the person had an appropriate plan to guard against malnutrition and was supported to maintain a healthy lifestyle.

Records showed that people had access to a range of health care professionals including GPs, a specialist dementia team, SALT staff, district nurses, chiropodists, opticians, and dentists. If staff were concerned

about people's health they referred them to the appropriate health care services and accompanied them to appointments. That meant that people supported to maintain a healthy lifestyle.

We spoke with a family member who told us, "The meals have gone down-hill since the new chef came."
We saw a visitor took a person who lived at the home to the Bistro for a drink. The bistro is situated on the ground floor and people can meet and socialise. They made the choice and stayed down for lunch in the restaurant. We spoke with them on their return, as we were aware the person's fluid and food intake was being recorded on the top floor dining room. The visitor told us, "Well, I tell them exactly what and how much [named person] has but I don't think it is always registered." We checked later and an adequate diet and fluid intake had been recorded by staff.
We spoke with a family carer who said, "With regards to fluids, the notes are always as accurate or as full as they should be."

Good

Is the service caring?

Our findings

People told us the staff group were pleasant and friendly. One person said to us, "They are very willing, but they are sometimes so busy." Another said, "They are always so obliging. If they cannot do anything for you, they'll get someone who can." Another said, "They all seem to try their best for you." We spoke with a visiting healthcare professional who told us, "The staff appear to be very caring. I have never seen anything that has caused me concern about the home."

A relative explained about a person that was admitted to hospital by ambulance. They explained they were accompanied all the time whilst at the hospital by a care worker that they were familiar with. They said, "I think that was wonderful that they could bring another worker up from downstairs in order that this particular care worker could accompany them."

We observed staff interactions with people and noted these to be caring and warm. One member of staff said, "I love it here, it's so rewarding." Staff treated people with dignity and respect throughout our visit for example with personal care. We heard one member of staff call one of the people who lived at the home by the term they preferred. The person later confirmed this was the term they preferred to be addressed by. We also saw where people were provided with personal care, doors were closed whilst this was undertaken, and we observed staff knocked and waited for a response before entering peoples' rooms.

One person said, "They always knock on the door before waiting for an answer to enter. I like that." When one person requested to go to the toilet when lunch was being served, a member of staff responded promptly, and ensured the person's meal was kept warm till they returned. We saw staff responding to preserve people's dignity without being prompted. We saw where a lady's skirt was raised above her knee, the care worker went to her and asked her permission to put her skirt down, which she duly did.

A family carer told us, "I'd say, by and large the carers are very good with my husband, very caring and patient." People explained they were not restricted to specific visiting times and they could visit later in an evening by arrangement with the staff. The bedrooms we were given permission to view were homely and contained personal memorabilia, which provided a familiar environment for people to live in.

People we spoke with said, "The carers are lovely, they always have time to speak with you", another person said, "The staff are really nice." We observed a member of care staff sit with a person who was becoming anxious. The staff member was talking about the person's family in a gentle voice and holding their hand, this calmed them down. We saw another two people who lived at the home began a heated discussion. Staff intervened, attempting to distract them by talking to them and speaking to both in a calm manner. A member of staff assisted one person out of the main sitting area in order to diffuse the situation. We looked at this person's care plans and confirmed these deflection techniques were part of the plan to distract the person and diffuse the situation before it escalated and caused behaviour that could challenge them or others.

We saw people who lived at the service were able to make their own choices. For example one person asked

mid-morning if they could take a shower. We saw the care staff took them aside. We later ascertained the member of staff enquired if they preferred a bath or shower and also what support they would like. This was done with the person's privacy and dignity in mind, away from the main lounge seating area. We saw the person was assisted and enabled to undertake their choice of personal care. The bedrooms and flats were spacious and many had been personalised with people's own furniture.

Good

Is the service responsive?

Our findings

We spoke with three people who said they were all involved in the care planning process and all said their family members were also involved in this process. One person told us, "I do feel they let me do as much as I can, they don't seem to take-over."

We spoke with a visiting relative who told us, "My mother has been here since [date given] I am happy with her care, you only get what you pay for these days." They added, "They [staff] keep in touch with me and I have no issues as yet."

People and when appropriate their families were invited to be part of the review process for care plans. A family visitor confirmed that they (and her siblings) were involved in the initial care planning of their relative and said they were always consulted with regard to any changes and reviews. Another visitor said, "I feel very happy that the staff know my mother's needs and how she changes from day to day. They seem to be in tune with her."

We saw there was one person being cared for on a one to one basis, so they always had a care worker with them, which changed periodically throughout the time we visited. Many of the care workers interacted with them, for example if they stopped and looked at a magazine on a table, they would engage in a meaningful conversation. A family carer commented that her relative had always been particular and the care staff understood this, bringing clothes out so that the person could choose herself.

Staff had access to people's plans of care and received updates about people's care needs through the daily staff handover meetings. The care files that we viewed were comprehensive, and showed regular reviews, suggesting the care processes were being well managed.

We looked at twelve care plans which were well detailed and had been recently reviewed. Pre-admission assessments and care planning linked to people's needs were individualised and detailed. However we found that where people had highlighted a preference of the gender of their carers prior to admission this was not always part of care plans. There was evidence of an up to date photograph, people's past history, allergies, likes, dislikes, wishes and aspirations and these were incorporated into the care planning to support care delivery. Lifestyle care plans were in place and detailed how people liked to spend their day. Staff were able to explain and demonstrated through the care we observed the support that people required.

There were notices around the home and posted in each person's post-box about the daily activities. We spoke with the activities co-ordinator and other activities staff. Activities were recorded for people on an individual basis, and each person had a one to one activity session once or twice a month for one hour. That meant people had individual stimulation on a topic they chose. Examples of this were poetry reading for one person, being taken out to the shops for another, room and personal effects tidying and hand massages for others. On the day of our visit there was a visiting 'PAT dog' which has visited once a week for the past three years. The dog was well received in the communal lounges as well as visiting people in their bedrooms.

There were other volunteers who assisted with the activities, one playing the violin and another organising board games and sing along.

We saw there had been a recent visit by a representative from the national activity providers association (NAPA). They visited annually and ascertained what activities were offered and how often people were engaged in meaningful person centred activities. The latest report from January 2016 recognised the work the five activities staff offered to people.

Two people had advance decision care plans in place and do not attempt resuscitation (DNARs) advance decisions One of these had been agreed with the person as they had full capacity. The other was agreed with the person's daughter who had lasting power of attorney (LPA) for health and welfare. Where the LPA was in place this was clear from documentation and there was a letter from the registered manager confirming who held it, and for what aspects of the person's life. That meant staff were clear about the area the LPA affected.

There were activities recorded in people's individual records and saw that activities were personalised. We saw that one person liked to arrange trips to the supermarket, and needed support by staff. The person said, "I go on the very odd occasion. That's my choice, I wouldn't want to go any more often." That meant care and support was tailored to individual's preferences and needs. We saw other examples of this where there was a mirror placed in the lift to allow a person with mobility needs to reverse their vehicle, and ensure their and others safety. We also saw where a person living with dementia, had reverted to reading and speaking their original language. The staff had produced language appropriate signs which promoted the person's dignity.

The provider had systems in place to record complaints. People and their family visitors that we spoke with said they knew how to make a complaint.
Records showed the service had received 27 written complaints in the last 12 months. Outcomes had been provided for each, and changes were made to the service, as a result of the outcomes. The registered manager explained that one complaint was about the time it took for staff to answer call bells. A computer has been installed and reports were produced that showed the longest times call bells remain unanswered. That meant staff monitored the response times of call bells and investigated if there were extended periods of time involved.

There were monthly meetings to plan activities, food and beverage meetings and meetings for people's relatives. People could make suggestions and changes to the running of the home and the meals on offer. There were minutes on display throughout the home for these meetings which provided those that were unable to attend, to keep abreast of changes.

Good

Is the service well-led?

Our findings

People we spoke with during the inspection gave us mixed opinions about the service, staff and registered manager, and included relatives of people in the home. One family member to a person living on the lower floors, told us that neither she nor her relative had met the registered manager or care service manager. They added their relative had been at the home for a couple of years and they visited the home daily. The person added, both the managers had been at the home for a few months and felt they could have made themselves, "Obvious to residents and family." A family carer in Beacon Knowle told us, "[named person] the registered manager couldn't have been more helpful." Another visiting relative told us, "The deputy manager is very approachable and definitely tries their best."

The service had a registered manager who understood their responsibilities in terms of ensuring that we were notified of events that affected the people, staff and building. The registered manager had a clear understanding of what they wanted to achieve for the service and they were supported by the staff group, the regional director and other head office staff. There was a clear management structure in the home and staff were aware who they could contact out of hours were that necessary.

All staff had detailed job descriptions and had regular team and supervision meetings which were used to support staff to maintain and improve their performance. There were separate supervision arrangements for the nursing staff as the registered manager was not qualified to undertake these as they were not a qualified nurse. Staff had access to paper and electronic copies of the provider's policies and procedures. Staff understood their roles and this information ensured that staff were provided with the same information which was used to provide a consistent level of safe care. Staff told us they could make comments or raise concerns with the management team about the way the service was run.

The provider's procedures for monitoring and assessing the quality of the service operated at two levels. The registered manager oversaw the staff that carried out a range of scheduled checks and monitoring activity to provide assurance that people received the care and support they needed. The registered manager also held regular meetings with all the departments and each floor manager on a monthly basis. The provider had also appointed an area manager to oversee the development of the home. They visited and observed the staff group and produced reports on their monthly visits. These regional manager's reports were also reviewed by the monthly provider's operational board meetings. This meant the most senior managers in the provider organisation knew how the service was performing.

The manager understood their responsibilities and displayed a commitment to providing quality care in line with the provider's vision and values. Staff were aware of their accountability and responsibilities to care and protect people and knew how to access managerial support if required.

We saw the system in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced. There was an in house maintenance team who undertook these repairs. Staff were aware of the procedure for recording and reporting faults and repairs. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as

hoists were serviced and regularly maintained.

We discussed the checks and audits the registered manager and staff conducted in order to ensure people received the appropriate support and care. The registered manager told us there were regular audits undertaken by the staff in order to ensure health and safety in the home was maintained. We saw records of the checks that had been undertaken to ensure the building was safe for people. These checks included the medicines system, care plans, accidents and incidents and people's weight loss or gain and their nutritional and dietary requirements.

There were regular meetings held for the people who used the service and their family or friends where they were enabled to share their views about the service. There were minutes displayed throughout the home which provided evidence of the changes implemented following the meetings.