Brooklyn Home Limited

Ann Slade Care Home

Inspection report

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Merseyside
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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 of Ann Slade care home took place on 18 January 2018 and was unannounced.

At the last inspection on 8 November 2016, we found that the registered provider was in breach of Regulation 17 (Good Governance). Following the last inspection, we asked the provider to complete an action plan to tell us what they would do to make the necessary improvements. We received an action plan that outlined what improvements the registered provider intended to make. At this inspection, we found that improvements had been made to meet the relevant requirements and the provider was no longer in breach of regulation.

Ann Slade is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ann Slade Care Home is located close to Southport town centre. The home can accommodate up to 24 people. Accommodation is provided over three floors which can be accessed by stairs and a passenger lift. Shared areas such as dining facilities and lounge space are located on the ground floor. There is car parking to the front of the building and a garden at the back of the home. At the time of the inspection there were 22 people living in the home.

A registered manager was 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 registered manager was supported by a care manager and deputy manager. The registered manager had delegated the responsibility for overseeing the day to day running of the service to the care manager. The care manager was in the process of applying to become the registered manager of the service.

At the last inspection on 8 November 2016 we identified a breach of regulation because the governance systems in place for monitoring the service were not robust because they had failed to identify potential risks to people with regards to the environment. At this inspection, we found that people were supported to live in a safe environment, free from hazards, and that the appropriate checks were in place to ensure this. The registered provider had taken action in accordance with our recommendation and had reviewed their procedures to ensure the safety of the environment. The registered provider had implemented a series of daily and weekly environmental audits to check the safety of the service.

We found that the registered provider had taken action to further develop and strengthen their recording procedures in respect of the best interest decision making process in accordance with the principles of the Mental Capacity Act 2005. Decisions that were made were thoroughly assessed to ensure the least restrictive option was chosen.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People told us that consent was sought and staff offered them choice before providing care.

The registered provider maintained detailed records of Deprivation of Liberty Safeguards and their efforts to ensure that any conditions attached to authorisations were adhered to.

All of the people we spoke with told us they felt safe living at Ann Slade Care home.

Medications were well managed and staff received training to administer medication safely.

Staff were able to describe the course of action they would take if they felt someone was being harmed or abused. All staff had been trained in safeguarding and understood the reporting procedures.

Staff were recruited safely and had the necessary checks to ensure they were able to work with vulnerable people. Staff were assisted in their role through induction, training and supervisions and staff told us they felt well supported in their role.

People's health care needs were addressed with appropriate referral and liaison with external health care professionals. The registered provider's records showed that staff maintained good contact with other professionals involved in people's care.

We sampled the food at Ann Slade and found it to be of good quality. The chef was aware of people's individual dietary requirements and these were catered to. People told us they were offered a wide range of food and the menu was changed regularly.

We observed interactions between staff and people living in the home to be familiar and caring. The service enabled one person to have their pet live with them at the care home because they understood how much this meant to the person.

Care plans were detailed, person centred and informative. People's likes and dislikes were reflected throughout care plans we viewed. This helped staff to get to know people and provide care based on their individual needs and preferences.

People had access to a complaints procedure which provided relevant contact details should people wish to make a complaint. Opportunities were provided for people and their relatives to comment on their experiences and the quality of service provided.

The care manager had put in place a series of audits (checks) to monitor the quality of the service and improve practice.

The care manager had notified the Care Quality Commission (CQC) of events and incidents that occurred within the home in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding Ann Slade care home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

A series of additional environmental checks had been implemented since our last inspection to ensure people lived in an environment that was safe from hazards.

People received their medicines as required from appropriately trained staff.

Safe recruitment practices were in place which ensured suitable staff had been employed. Staff received training in safeguarding vulnerable adults.

Is the service effective?

Good

The service was effective.

People's rights and liberties were protected in line with the Mental Capacity Act 2005 and best interest decisions were made after a thorough assessment process.

Staff worked with health and social care professionals to make sure people received the support they needed.

Staff were sufficiently trained and supported to ensure that they had the appropriate skills and knowledge to meet people's needs.

Is the service caring?

Good

The service was caring.

Staff were kind to people. People's dignity and independence was respected. Staff provided examples of how they ensured people's privacy.

People's visitors were welcomed at the service which encouraged relationships to be maintained.

Staff made referrals to advocacy services where required to promote people's involvement in making decisions about their

care.

Is the service responsive?

Good

The service was responsive.

People's care records contained personalised, relevant and up-to-date information about the support they required.

There were activities held for people living in the home to promote social interaction and stimulation.

A process for managing complaints was in place and complaints were dealt with appropriately.

Is the service well-led?

Good

The service was well-led.

People, relatives and staff spoke positively about the overall atmosphere and running of the home.

People were able to share their views and were able to provide feedback about the service.

Systems and processes were in place to assess, monitor and improve the safety and quality of the service.

Ann Slade Care Home

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 18 January 2018 and was unannounced.

The inspection team consisted of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case, the care of someone living with dementia.

Prior to the inspection we contacted the local authority quality monitoring team to seek their views about the service. We were not made aware of any concerns about the care and support people received. We also considered information we held about the service, such as notification of events about accidents and incidents which the service is required to send to CQC. Before the inspection, we asked the registered provider to complete a Provider Information Return (PIR). This is a form that we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan how the inspection should be conducted.

As part of the inspection we spoke with 10 people who used the service and five relatives. We visited the office and met with the care manager and deputy manager of the service. We spoke to three members of care staff, the activities co-ordinator, the maintenance person and the chef. We also looked at four care plans for people who used the service, three staff personnel files, staff training and development records as well as information about the management and auditing of the service. We observed the lunchtime service and sampled the food available. We observed staff interaction with people who lived at the home at various points during the inspection.

Good

Is the service safe?

Our findings

At the last inspection on 8 November 2016 we identified concerns in relation to the safety of the environment because there were exposed hot pipes in a person's bedroom, the shower room on the second floor had a trestle window that did not have a restricted opening in line with health and safety guidance and there was no alarm on a fire exit door to inform staff that the external fire door had been opened in the shower room. During this inspection, we checked these areas and saw that the registered provider has taken appropriate action to address these issues and they no longer posed a risk to people's safety.

We saw that arrangements were in place for checking the environment at the home to ensure it was safe. Senior staff told us and records confirmed, that they completed daily environmental checks during their 'walk arounds' to assess the environment for any potential hazards. The registered manager appointed a care manager who also completed weekly and monthly overview checks to monitor the suitability and safety of the environment.

The service employed a maintenance member of staff who was responsible for any repairs to the property. We reviewed the maintenance records at the service and saw that the appropriate checks were in place to ensure the safety of the equipment and building. These included; bed rail monitoring, portable electrical appliance testing and fire and emergency lighting checks. We saw that the last electrical safety check in February 2017 had identified some concerns at the service and we were provided with evidence which showed that these were in the process of being addressed to ensure compliance.

Risk assessments were completed in relation to the environment on areas such as infection control, fire safety, electrical safety and control of substances hazardous to health. Each risk assessment considered the hazard, who might be harmed and how the risk was controlled. Actions taken to mitigate the risk were clearly recorded, for example, hot water temperatures were controlled by thermostat mixing devices to prevent the risk of scalding.

We saw that fire procedures in the event of an evacuation were clearly marked out, and regular mock fire drills were completed to check evacuation procedures. A fire safety risk assessment was completed in March 2017. People had Personal Emergency Evacuation Plans (commonly known as PEEPs) which were personalised and reviewed regularly, to support evacuation in the event of an emergency. These contained important information on people's mobility needs and what assistance they required in the event of an emergency. We observed that one fire exit had furniture stored nearby which could be an obstacle in the event of evacuation and brought this to the attention of the care manager at the time of our inspection who assured us this would be addressed.

We asked people if they felt safe living at Ann Slade care home. Comments included; "Yes I do" and "Of course {I feel safe}."

The building itself was warm and clean and free from any unpleasant odours. Staff had access to personal protective equipment and were observed using this when delivering care in accordance with infection

control guidance. We reviewed a number of cleaning checklists which showed staff completed a variety of daily cleaning tasks alongside regular 'deep cleaning' duties which covered areas such as the laundry room, kitchen and dining room. We reviewed the laundry arrangements in the basement of the home and noted that the service had a system in place to separate clean and soiled clothing. Ann Slade care home had achieved a 'Good' rating from the local food standards authority on 9 January 2018. This demonstrated hygienic food handling practices.

On the day of our inspection, there were sufficient staff on duty to meet people's needs and people did not have to wait long for support. Staff told us there were sufficient staff to support people safely and the staffing rotas we reviewed evidenced this. The daytime staffing levels consisted of three carers, a senior carer, chef, domestic assistant and maintenance assistant. The care manager told us that these numbers were always maintained at a minimum and an additional staff member was rostered on a regular basis so staff could complete 1-1 time with people in the local community. The staffing numbers reduced to two carers during night shifts with access to on call support in the event of an emergency.

People had call bells in their bedrooms to attract staff attention when required. We noted one person had been moved to a temporary room and their call bell was not accessible from their position. We raised this with the manager who provided assurances that they would address this immediately.

We looked at how staff supported people with the management and administration of their prescribed medicines. All the people we spoke with said they got their medication when they needed it and there was no issues around this. Staff who administered medicines had received training to ensure they had the skills and knowledge to administer medicines safely to people. We checked a sample of some medicines being held and found that these were appropriately secured and the quantities were correct.

Some medicines need to be stored under certain conditions, such as in a medicine fridge, to ensure their quality is maintained. We saw that the temperature of the fridge was not recorded consistently and brought this to the attention of the care manager during our inspection who assured us this would be implemented as part of the staff daily checks.

We reviewed Medication Administration Records (MARs) and saw these were completed accurately to evidence when medication had been administered. People's photographs were clearly visible to prevent wrong administration. Staff were given advice regarding action to take if the person refused their medication. For example, one person's care record outlined that they sometimes spat out their medication and reminded staff to explain the reason the medication was prescribed and why it was important to take it. If this was not effective, staff were to offer the medication at a later time. If several attempts were ineffective, then staff were reminded that liaison should be held with the person's GP. This helped ensure that staff knew what levels of support to provide to people. Some people self-administered their own medication such as inhalers. Staff had completed the relevant risk assessments to monitor this.

A medication policy was in place and regular audits were completed to check balances of stock, recording and any changes to a person's medication. The care manager told us the responsibility for completing these audits was divided among the senior care staff to promote more effective and robust oversight.

Risks to people's health and wellbeing were appropriately assessed and reviewed in areas such as nutrition, falls and pressure area care. We noted that risk assessments were sufficiently detailed and were reflected in the associated care plan. An electronic line graph was completed which clearly depicted any change in risk level so that staff could monitor any deterioration in people's mobility, weight loss or skin integrity.

We looked at the management of accidents and incidents at the service. Staff recorded details of accidents and incidents on the person's individual electronic care record. This included a description of the incident, the location where it occurred and whether there was any witnesses. We saw that action taken in response was clearly recorded. For example, for incidents of falls, staff had recorded that 24 hours' post falls observation was completed. The care manager also maintained oversight through the use of audits in order to analyse potential trends in respect of accidents and incidents.

Staff told us that they had received training in safeguarding vulnerable people and were able to describe what course of action they would if they felt someone at the service was being abused. Contact details for the local authority safeguarding team were displayed in the communal area of the home.

We checked how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We reviewed three personnel files of staff who worked at the service and saw that there were safe recruitment processes in place including; photo identification, references from previous employment and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that staff are suitable to work with vulnerable adults in health and social care environments.

Good

Is the service effective?

Our findings

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 be as least restrictive as possible.

We saw that the procedures in place for recording best interest decisions had been further developed following our last inspection on the 8 Nov 2016 in accordance with a recommendation we made. Where people were assessed as not having capacity to make a particular decision, consultation was held with family members and healthcare professionals and a decision was made in the person's best interests. This process was used in respect of decisions specific to the individual such as the person's ability to consent to regular room checks and the person's ability to consent to bed rails. We noted that there was a clear and detailed rationale as to how staff made these decisions with a risk/benefit analysis and a focus on the least restrictive option in accordance with the principles of the MCA.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection, there were six people for whom a Deprivation of Liberty Safeguard authorisation had been granted. We checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met and found that they were. For example, a condition attached to one authorisation was for the registered provider to maintain a log of all objections the person made to living at the home. We reviewed the records and saw these records were detailed and well maintained. This ensured that people's rights and liberties were being protected in line with the MCA.

Staff had received training in the MCA and were aware of their roles and responsibilities in relation to the Act. Staff understood the importance of offering people choices in respect of how they wanted their care delivered. Care files contained reminders such as 'Always ask if the person would mind staff entering to tidy their room a little' and to 'encourage choice regarding clothing.'

Most people spoke positively about the variety and quality of food on offer at the home. Comments included; "It's alright, get a choice every day", "Fine, don't get the same thing every day", "Best thing is the individual trifles", "Average", "Not bad at all" and "If you want a cake or biscuit you can ask for it."

During our inspection, we observed that people were served a variety of breakfast items such as boiled eggs, scrambled eggs, jam on toast or porridge. We saw that people were offered a choice and were able to eat their meal where they wished. During the lunchtime service, we saw that people who chose to eat in the dining room were served at tables which were laid out with cutlery, condiments and a table cloth. Other people were served their food in their room. We sampled one of the meals available which was 'homemade chicken pie' and found it to be of good quality. People were offered drinks throughout the day.

We saw that the chef maintained a record of questionnaires issued to all people living in the home which had been completed to document their likes/dislikes, favourite meals, allergies and any special dietary needs. People's dietary preferences and needs were catered for such as for people who had diabetes. The chef told us that people were given sugar free jelly and desserts.

People were supported and cared for by trained staff who were familiar with people's needs and wishes. The care manager provided us with a staff training matrix and we viewed certificates within staff recruitment files which demonstrated that staff had received training in topics considered mandatory such as moving and handling, fire safety, safeguarding, food hygiene and medication administration. Some staff had received additional training in relation to more detailed aspects of their role such as dementia in people with learning disabilities and life stories and reminiscence. Staff spoke positively about training they had received and how they have developed their knowledge base as a result. For example, one staff member told us that as a result of training, they were aware of the need to be mindful for the reason behind behaviour and understood that a person who is presenting as angry or agitated could be in pain but unable to express it. We saw that eight out of eleven care staff had achieved, at least, an NVQ level 2 or above. This helped to ensure that people were cared for by staff that had the necessary skills to support them safely.

We saw that senior members of staff had recently attended the NHS 'React to Red' training which relates to the identification and prevention of pressure sores. The care manager had shared their newly acquired knowledge with ensured all of the care team and had developed a new policy in respect of pressure area care. We saw that staff had signed this policy to indicate they had read and understood the policy.

Staff reported feeling well supported in their role through induction, supervisions and regular training. We reviewed the supervision schedule and saw that all staff had regular supervisions. Supervision sessions between care staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. Staff also received an annual appraisal. Staff we spoke with told us they also felt able to raise any concerns informally.

People at the home were supported by staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as their GP, community mental health team and optician. We saw that staff made referrals when required to services such as dermatology, occupational therapy and speech and language therapy. People told us they see a chiropodist each month if they need it. Records of contacts and health care appointments were documented within people's electronic care record so staff were aware of any treatment required or advice given. For example, one person's care record contained advice from the speech and language therapist regarding the need for staff to promote good posture when assisting the person to eat. A vaccination log was kept for each person and whether they had received the flu jab. The care manager told us of their efforts to try to ensure each person was seen by the dentist for regular check-ups.

The care manager had completed their own assessment using research online to ask 'Is your care home dementia friendly' and identified a number of areas for self-development. The care manager had told us they had decorated the dining area in yellow paint to promote hunger and had redecorated a bathroom in a seaside scheme following research to make the home more dementia friendly. The care manager told us of their refurbishment plans to include further adaptations to assist people living with dementia to orientate themselves around the home. There were no menus on display although the chef showed us a proposed pictorial menu which they planned to implement.

Good

Is the service caring?

Our findings

It was evident that staff knew people well and that positive relationships had been formed. We overheard natural conversations between staff and the people they supported and each staff member addressed people by name. Staff approached people in a gentle manner and offered reassurance and tactile touch when needed. People's relatives told us they were happy with the care given to their loved one. One relative told us; "When we walk away, we are happy."

We observed that the atmosphere around the home was calm and peaceful. The registered provider's welcome pack outlined that they pride themselves on their 'home from home atmosphere'. This was reflected in our observations and through discussions with people. One relative commented, "[The home] feels cosy, safe and homely. To me [the décor is] a bit tired, not been to others to compare. Feels friendly with staff, feel that's more important than beautifully decorated and staff not being right."

Staff were able to describe how they promoted people's dignity and respected their privacy. For example, knocking on the person's bedroom door and announcing themselves before entering, asking permission before providing support. During our inspection, we observed that staff responded promptly and effectively to one incident that happened in the communal area of the home. This was handled quickly, kindly and without fuss and in a manner which respected and preserved the dignity of the person.

People living at the home were supported to remain as independent as possible and this was supported by staff. People told us "[I] dress on my own" and "[I'm] quite independent, if there was something I couldn't do I would ask." We saw that one person still accessed the community independently. Staff had engaged in consultation with this person who signed a document to confirm they felt safe going out without staff support and would return at a specified time. Care records outlined people's abilities and any assistance they required, for example, one care file outlined that the person could still read post and paperwork and reminded staff that it was better for the person to continue to read their mail to keep independence but directed staff to still ask if the person required help with anything.

Records showed that all people were consulted with decisions about their care such as how often they wanted night checks. Some people outlined that they wanted 2 hourly checks or none at all to promote undisturbed sleep. Staff respected these wishes where the person had consent to make this decision and the best interest process was used if they did not. People told us they could request a gender specific carer and told us this was respected, albeit they may have to wait a little longer.

People were supported to maintain relationships with those important to them. Visitors were welcomed and could stay for mealtimes with advance notice. The service had allowed one person's pet cat to move into the home with them because the person valued their relationship with their cat and did not want to leave them. A post-box was displayed in the communal area alongside envelopes to enable people to send letters to their loved ones if they chose.

We saw evidence of staff liaison with advocacy services for people living in the home and that referrals had

been made where appropriate to services such as 'Voice ability.' Independent Mental Capacity Advocates (IMCAs). IMCAs represent people where there is no one independent, such as a family member or friend to represent them. People's religious and cultural needs were supported. We saw evidence of contact made to a local church in response to one person's request for a priest to visit.

Information on people's communication needs and any barriers to communication was recorded in files. For example, one person's care file outlined that the person had an inability to name some words and when this occurred they could become frustrated. Staff were encouraged to promote one to one conversation with this person, to be patient when engaging verbally and to minimise distractions to communication such as background noise.

People's records were stored electronically in the main office. Computers were password protected. This helped to ensure that confidentiality was maintained. We reviewed the training matrix which showed that the majority of staff had received training in equality, diversity and inclusion.

Good

Is the service responsive?

Our findings

The registered provider had processes in place to receive and act on complaints. People told us they would speak with the manager if they had any concerns or complaints. A complaints policy was on display in the communal area of the home for people to access if they required it. People told us, "If I have concerns, will speak to someone" and "No complaints, in general OK." A relative told us, "[I've] never found any reason to [complain] he's well looked after…if had a problem would speak to them before speaking to you CQC."

The registered provider's records showed the last formal complaint was received in May 2016 and they had not received any more since our last inspection. One informal complaint was recorded which related to concerns that a family member had regarding their loved one's hygiene. We saw that appropriate action had been taken in response and preventative action was implemented which included increased monitoring of the person. A record of compliments and thank you cards were kept whereby people wrote to show their appreciation of staff. The care manager was particularly proud of one feedback which thanked staff for preserving the person's dignity, humour and the person's self to the end.

Although some people could not recall being involved in the planning of their care it was evident that they and their relatives had been consulted in the initial assessment of their needs and care plan because people's individual likes and dislikes were recorded and people signed their own plans where able. The care plans we saw recorded information on areas such as; oral health, skin care, mobilisation and personal care. A care plan provides direction on the type of care an individual may need following people's needs assessment. Care plans were specific to the individual and there was reference to people's social background and life story to get to know people's social care needs in more detail. These records, along with staff's daily notes meant care files contained important information about the person as an individual and how they wanted their care delivered.

We saw that people's needs were reviewed regularly through a traffic light system which was displayed on a whiteboard in the staff office for quick referral. Each individual was allocated a colour to signify their level of dependency and any changes were promptly recorded. Staff told us this was a useful visual tool which enabled them to quickly identify if someone had a deterioration in their health or well-being which meant they required extra support. Each person's needs were checked by staff on each shift and any changes to their care needs were discussed. The care manager then completed an overall review of the person's needs on a regular basis. This overview provided an explanation as to why people's needs had changed; for example, one person's dependency level had gone from green to amber due to an ear infection.

A resident key information folder was kept with important person centred information on people's individual GP, mobility needs, basic care needs, photo ID, communication aids and relevant health and allergy information. This information was useful when transferring between services or in the event of emergency or urgent hospital admittance.

Quality assurance surveys were issued to people using the service on an annual basis as a means of gathering feedback regarding the quality of the service. The next set of surveys was due to be re-circulated in

early 2018. We reviewed last year's results and saw that most people answered positively and indicated they were very satisfied with the service they or their loved one received. People answered in the affirmative when asked, 'Are the management of the home approachable?' and 'Do the staff treat you with dignity and respect?' People also had the opportunity to record their comments regarding the service. We reviewed a variety of these forms and saw people had made a variety of comments such as; 'Ann Slade care home has a warm and friendly atmosphere' and 'The staff are amazing and very welcoming.' We could see that action was taken in response to areas for improvement identified, for example, feedback was received that the dining room required re-decoration and we saw this had been actioned. A comment book was on display in the communal area for people to access. The care manager told us that people wrote in the book and made suggestions from time to time.

We saw evidence that resident meetings were held on an ad hoc basis to keep people up to date with changes at the service. We reviewed the minutes from the last meeting held in September 2017 which showed changes to the service were discussed. We saw that people had suggested improvements to the service such as the need for coat hooks in the lounge area. We saw that action taken in response was recorded, for example, a coat stand was purchased.

People had access to activities within the home and some people could access the local community with the support of staff if they chose. Staff told us they worked additional shifts where they were supporting a person on a one to one basis. One member of staff told us they were on a one to one shift the following day and planned to take a person shopping for new clothes.

An activities co-ordinator was employed by the service for 28 hours a week. They also assisted with cooking on a Sunday. The activities co-ordinator explained that they developed the activities in accordance with people's needs and preferences which had changed in the years they had worked for the service.

We observed people at the home knitting, watching TV and reading the daily newspaper that was provided. Some people told us they had been out in the local community with staff support. Other people told us they enjoyed the quizzes and had recently been to the pantomime. An activity assessment record was kept to record what activities each person had engaged with and contained observations such as 'person liked the cheese and biscuits and fruit tasting afternoon' and 'enjoys watching films, will be going to the panto.'

The service was not supporting anyone who received palliative care but had given consideration as to their processes in respect of people at the end of their lives. The staff training matrix showed that some staff had received training in 'death, dying and bereavement' and 'eating and drinking in the last days of life'. Care records contained information in respect of whether people had completed 'Do Not Attempt Resuscitation' (DNAR) forms and this was also recorded through colour code on the whiteboard in the office. Some people had an end of life care plan within their files, for example, one person had specified they wanted a cremation service. The care manager provided us with written confirmation that senior carers had booked to attend advance care planning training from a local hospice in the near future.

Good

Is the service well-led?

Our findings

At the last inspection on 8 November 2016, we found that the registered provider was in breach of Regulation 17 (Good Governance). Following the last inspection, we asked the provider to complete an action plan to tell us what they would do and by when to improve. We received an action plan that outlined what improvements the provider intended to make. At this inspection, we found that improvements had been made to meet the relevant requirements and the provider was no longer in breach of regulation.

The registered provider had addressed the concerns with regards to hazards within the environment identified during our last inspection. The care manager had implemented a series of environmental checks including daily monitoring to assess the suitability and safety of the environment. The care manager had further developed the recording of the best interest decision making process in accordance with a recommendation we made during the last inspection.

We saw cleaning audits and weekly environmental checks were completed which included checks on equipment such as commodes, hoists and chairs. The care manager's audit scored each area accordingly and made recommendations, for example, commode needs to be replaced and targeted areas to be cleaned. We saw that each area of the home was subdivided into zones and audited monthly on a rotational basis. We saw that the care manager's audit completed in march 2017 scored the environment 79.5%. This improved to a score of 97% in October 2017.

The care manager completed a monthly audit of falls to examine if there were any trends or patterns which could then be used to inform future care planning. The audit reviewed who had fallen, the area in which they had fallen and the severity of harm. We reviewed the last audit completed in December 2017 which had identified no patterns or links with regards to the falls although identified that more occurred in the communal lounge than on previous audits. Each person who had fallen had been analysed and any contributing factors for the fall such as UTI or poor health were recorded. The audit recognised that one person's mobility was good during the morning but deteriorated at night. The care manager directed staff to encourage the person to rest for short periods so they were well rested and the chance of falls would be minimised. Other audits included audits in respect of staff training and accident and incidents.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported by a care manager and deputy manager.

The registered manager was also the nominated individual and director of the company that owns the service. The registered manager had delegated the responsibility for overseeing the day to day running of the service to the care manager. The care manager was in the process of applying to become the designated registered manager of the service. The care manager felt well supported by the registered provider of the company and told us they were 'lovely' and 'supportive'.

The registered provider's PIR states that the management have an 'open door policy'. This was reflected through our discussions with staff and people who told us they felt they could approach the management if they had a concern. Staff spoke highly of the care manager and deputy manager and felt they were approachable, caring and listened to them. Staff comments included; "The care manager is a great manager, they are the best I've had", "They [care manager] are a good person to learn from" and "It is well-led, we know where we are up to and are constantly communicating." Another staff member told us how the service promoted their ongoing training and development and offered them the opportunity to complete a management and leadership qualification and supported them through this.

We reviewed team meeting minutes and saw this covered discussions around individual needs, recording and documentation. The care manager told us that to encourage staff to speak freely, they had implemented a suggestion box prior to team meetings so that staff could raise any queries/concerns anonymously which could then be addressed within the meeting. They felt this was an effective tool in creating an open and transparent culture within the service. Staff had access to out of hours 'on-call' support in the event of an emergency or issue arising. We were told that on-call support was provided by the care manager, deputy manager or senior members of staff.

The registered provider had a range of policies and procedures for the service that were accessible for all staff on topics such as safe use of bed rails, whistleblowing and safety of the premises. Policies and procedures support decisions made by staff as they provide guidance on best practice. Staff had signed to show they had read and understood.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding Ann Slade care home. The care manager maintained a log of all referrals made for ease of reference.

From April 2015 it became a legal requirement for providers to display their CQC (Care Quality Commission) rating. The rating from the previous inspection for Ann Slade was displayed for people to see at the entrance to the home.