Care UK Community Partnerships Ltd

Hadrian Park

Inspection report

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22 January 2018

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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

The inspection took place on 9 and 22 January 2018. The first day of the inspection was unannounced. This meant that the provider and staff did not know we were coming.

We last inspected the service in January 2017 and at that time identified breaches in two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were related to safe medicines management and good governance.

We took action by requesting the provider send us an action plan stating how and when they would achieve compliance. During this inspection we found there had been improvements made in line with the provider's action plan. As a consequence of these improvements the service was no longer in breach of the regulations detailed above.

Hadrian Park 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.

Hadrian Park can accommodate up to 74 people in a two-storey purpose built building. At the time of this inspection there were 55 people using the service.

The service was divided into three units, Lilly, Chester and Poppy. The Lilly unit provided residential care on the ground floor whilst the Chester unit, also on the ground floor provided care for people living with dementia. Upstairs the Poppy unit provided accommodation for people who needed a higher level of support. The first floor was accessed by stairs or a passenger lift. There were four dining areas and a variety of communal living areas.

The service had a manager in place. They had submitted an application to become registered manager and that process was underway at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection we identified that people's medicines were not always managed safely. At this inspection we found that improvements had been made in the records for oral medicines, however improvements were still needed for the records of topical preparations and the guidance for when required medicines. We have made a recommendation about this.

Safe recruitment procedures were in place and appropriate pre-employment checks were undertaken.

There was a sufficient number of staff on duty to care for people safely. People's dependency levels were

calculated regularly and used to determine the number of staff needed for each shift.

Care records contained detailed risk assessments. People had individual personal emergency evacuation plans in place. Accidents and incidents were recorded and analysed to look for patterns or trends. Regular maintenance checks and repairs were carried out and all areas of the service were clean and tidy.

The majority of staff were up to date with training and additional training courses linked to the needs of the people using the service had been completed by staff. Some training was not included on the matrix and this made keeping track of training more difficult.

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.
Requests for DoLS authorisations were being submitted appropriately. Capacity assessments were being undertaken and best interest decisions were being recorded.

Staff felt well supported and regular supervision sessions and annual appraisals were planned.

People were supported to maintain their health and wellbeing and had access to health professionals when needed.

People were happy with the food they received. There was a varied menu containing well balanced nutritious options. Snacks and drinks were available throughout the home for people to access as and when the wanted. People's weights were monitored regularly and expert advice sought from dieticians if there was any cause for concern.

People and their relatives were happy with the way care was delivered and happy with the staff approach. Staff interacted positively with people who used the service and had a good knowledge of the people they cared for. Relatives were made to feel welcome and were involved in the care planning process.

Staff provided care in a way that protected people's privacy and dignity and promoted independence. Advocacy support from external agencies was available should anyone require it.

People were receiving care that was tailored to their individual needs. Care plans contained detailed information, including life history, to help staff support people in a personalised way.

There was a small team of staff who were responsible for co-ordinating activities and there was a varied timetable of events each day.

There was a complaints procedure in place and people knew how to make a complaint if necessary.

People had end of life care plans in place and all staff had undertaken training in end of life care.

Equality and Diversity was part of the provider's mandatory training requirements and people were cared for without discrimination and in a way that respected their differences.

A more effective system of audits was taking place. Although they had not identified every issue we found the manager made changes to audits immediately in light of feedback give throughout the inspection to ensure they were even more robust going forward.

Records contained accurate and up to date information relating to people's care needs.

Staff meetings took place every two months and staff felt able to discuss any issues with the manager. Regular staff surveys were also conducted and action plans drawn up to address any issues raised. Staff spoke highly about the new manager and felt significant improvements had been made.

Feedback was sought from people using the service and relatives in a variety of ways. Meetings were held, telephone surveys conducted and a suggestion box was also in place.

The service had close links with healthcare professionals who gave positive feedback regarding the knowledge and cooperation of management and staff.

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 always safe.

Medicines, including controlled drugs, were stored safely, administered appropriately and disposed of correctly. There had been an improvement to medicine records but further work was still needed.

Safe recruitment procedures were in place and appropriate pre-employment checks were undertaken.

The service was staffed at an appropriate level to safely meet people's needs.

Is the service effective?

Good

The service was effective.

Most staff were up to date with training but records did not accurately reflect all training information.

Staff felt well supported. The manager had an annual planner in place for staff supervision sessions.

DoLS requests were being submitted appropriately and best interest decisions were being made where people lacked capacity.

People were supported to maintain their health and wellbeing and their nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were happy with the care they received. Relatives were welcome to visit at any time and were involved in planning their family member's care.

Staff treated people with dignity and promoted independence wherever possible.

Advocacy support from external agencies was available should anyone require it.

Is the service responsive?

Good

The service was responsive.

Care plans contained information to help staff support people in a person centred way and care was delivered in a way that best suited the individual.

An effort was made to engage people in activities that were meaningful to them.

There was a complaints procedure in place and people knew how to make a complaint if necessary.

End of life care plans were in place and staff had received the appropriate training to support people at this time.

Is the service well-led?

Good

The service was well led.

Records contained accurate and up to date information relating to people's care needs.

The quality of the service was monitored by system of audits. Feedback was sought from people using the service and their relatives and any issues identified were acted upon.

Staff meetings took place every two months and staff felt able to discuss any issues with the manager.

The service had close links with healthcare professionals who gave positive feedback regarding the knowledge and cooperation of management and staff.

Hadrian Park

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 9 and 22 January 2018 and the first day was unannounced.

The inspection team consisted of one adult social care inspector, two pharmacy inspectors and two experts 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.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We also contacted the local authority commissioners for the service and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spent time with people living at the service. We spoke with 15 people who used the service and 16 relatives. We spoke with several members of the staff team including the manager, deputy manager, operation support manager, regional director, quality development manager, business manager, activities co-ordinator, seven care staff, a member of the housekeeping team, the cook and the maintenance person. We also spoke with a community matron, district nurse and occupational therapist during our visit.

We reviewed six people's care records and four staff files including recruitment, supervision and training information. We reviewed medicine administration records for people as well as records relating to the management of the service.

We also carried out observations using the short observational framework for inspections (SOFI). SOFI is a

tool used to capture the experiences of people who use services who may not be able to express this for themselves.

Requires Improvement

Is the service safe?

Our findings

At our inspection in January 2017 we found that people's medicine records were not always accurate or complete. This was a continuing breach of our regulations. We took action by requiring the provider to send us an action plan setting out how they would address this issue. During this inspection we found improvements had been made. The provider was no longer in breach of regulation however further improvement was required in some areas relating to medicine management.

People using the service confirmed they received their medicine regularly and staff supervised the taking of the same. One person told us, "I get tablets every day; they [staff] bring them and make sure I take them."

We looked at the medicine administration records (MARs). We found residents had a photograph, as well as their GP details and their allergy status was recorded which helped to keep them safe.
We found the administration of people's prescribed oral medicines was clearly recorded and non-administration codes were used correctly. However some medicines were prescribed with a variable dose i.e. one or two tablets to be given. We saw the quantity given was not always recorded meaning that records did not accurately reflect the treatment people had received. Also for one person the records made of stock carried forward from a previous supply was not accurately recorded on two occasions and no explanation could be given by care staff for the discrepancy.

We also found for some people, where care staff applied prescribed creams and ointments as part of personal care through the day or when people first got up or went to bed, there was no guidance or records in place. We found some cream application records were not fully completed and some records showed that staff had not applied some creams at the frequency prescribed.

Medicines that are administered as a patch applied to the skin were prescribed for several people in the home. A system was in place for recording the site of application. This is necessary because the application site needs to be rotated to prevent side effects. We looked at the current MAR for one person prescribed a medicine that required regular blood tests. Arrangements were in place for the safe administration of this medicine.

We looked at the guidance information kept about medicines to be administered 'when required'. Arrangements for recording this information were in place for some people however some of these records were not accurate. For example, we looked at one record for a person who had 'when required' guidance in place for a medicine prescribed for pain; however the maximum dose recorded was incorrect. We looked at another record for a person who could not notify staff when they required pain relief medicine there was no guidance to inform staff when to give this medicines. In addition, staff did not always record the reasons for administration so it was not possible to tell whether these medicines had had the desired effect.

We looked at how medicines were stored. Appropriate checks had taken place on the storage, disposal and receipt of medication. Staff knew the required procedures for managing controlled drugs. Controlled drugs are medicines which are subject to stricter controls as they may be at risk of misuse. We saw that controlled

drugs were appropriately stored and signed for when they were administered. Eye drops, which have a short shelf life once opened, were marked with the date of opening. This means that the home could confirm that they were safe to use.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the provider had completed medication audits and identified some issues however these had not identified all of the issues we found. When we gave feedback on these issues the manager took immediate action to amend the audit system in an attempt to minimise reoccurrence. We will monitor the effectiveness of this at our next inspection.

We recommend the provider should review the medication plans for 'when required' medicines, the guidance and records kept for topical preparations and the records for variable dose medicines.

We looked at the staffing level within the service. The manager told us the service was fully staffed at present with no vacancies. A dependency analysis was completed on a monthly basis. People's care needs were assessed and a corresponding 'score' was input into the electronic dependency tool. The number of staff hours required to provide a safe level of care was calculated by the tool and records showed that at the time of our inspection the service had more staff on duty than the recommended minimum. One member of staff told us, "I haven't seen staff rushed, stressed or unhappy. I've worked at and visited other homes where staff are rushed and buzzers always ringing. There is none of that here, staff all have a smile."

People we spoke with felt there was sufficient staff on duty. One person told us, "I think there are plenty of staff about all the time, I've had no problems." Call bells were answered promptly throughout our inspection. People told us staff responded quickly if they needed any help or support. One person told us, "I've used [my buzzer] quite a few times and the girls [staff] always appear quickly, they are pretty good"

Safe recruitment procedures were in place and appropriate pre-employment checks were undertaken. When new staff members were recruited references were obtained and disclosure and barring service (DBS) checks done. The Disclosure and Barring Service carry out a criminal record and barring checks on individuals who intend to work with children and vulnerable adults. This helps providers make safer recruiting decisions and also prevents unsuitable people from being employed.

People told us they felt safe using the service. One person told us, "I have had no problems, I do feel very safe" Another person said, Relatives we spoke with were also confident their loved ones were kept safe. One relative said, "My [relative] has been here for two years and I feel they are very safe at this home" another relative said, "My [relative] has been here for five years and I feel they are safe and well looked after by the staff."

Care records contained detailed risk assessments which addressed each person's identified areas of risk. This meant that staff had access to information explaining steps to take to minimise risk and ensure people were kept safe wherever possible.

Policies and procedures were in place to safeguard people from abuse. Staff had received safeguarding training and there was a safeguarding policy in place that provided guidance on the types of abuse that can occur in care settings and how staff could report them. Staff said they would not hesitate to report any concerns they had. One member of staff told us, "I always think it should be somewhere I would be happy to have my Nana so if I was to see anything I was concerned about I would report it straight away."

The provider also had a whistleblowing policy in place. Whistleblowing is when a person tells someone they

have concerns about the service they work for. Staff were aware of how to confidentially report any such concerns although none of the staff we spoke with had ever needed to take such action.

Accidents and incidents were recorded and monitored monthly to look for patterns or trends that may indicate a need for action to prevent further incident. Details of any investigation undertaken, lessons learned or action taken such as referring people to the falls team were clearly recorded.

All areas of the service were clean and tidy with no areas of malodour. We saw staff using personal protective equipment (PPE) such as disposable aprons and gloves. The kitchen had been awarded a five star hygiene rating by environmental health. One person told us, "The home is clean and tidy and so is my room. There is a lovely atmosphere here."

Regular maintenance checks and repairs were carried out. These included checks on the premises and equipment, such as fire equipment, water temperatures and hoists. Other required inspections such as gas safety and electrical hardwiring had also been completed. Fire drill records indicated staff had not always responded appropriately or been sufficiently organised during the exercise. We discussed this with the manager who confirmed that fire awareness training was due for renewal and showed us details of the upcoming course and what it covered.

People had individual personal emergency evacuation plans in place that explained to staff the support people needed to be moved to a place of safety in the event of an emergency situation. This information was kept in a fire emergency file located close to the main exit. The file also included a floor plan of the building with the fire zones clearly marked. A business continuity plan was in place which covered emergency situations such as staff shortages, adverse weather and pandemic.

Good

Is the service effective?

Our findings

People we spoke with and their relatives were happy that staff had the necessary knowledge and skills to provide the required level of care. One person told us, "From the way they help in the shower to how they support me whilst walking or eating or just by being there with me, I would say they have all the training that is needed." Another person said, "I don't think untrained staff would be able to look after me this well, they know to look for signs and symptoms." A relative told us, "As a family we wouldn't leave [family member] here if we weren't happy with the care. The staff know what they're doing."

Training was recorded on a matrix. Each staff member also had an individual training record on their personnel file. We found that the individual records did not always match the information on the training matrix and some courses that were identified as 'mandatory' on the individual record did not appear on the matrix at all. Mandatory training is training that the provider thinks is necessary to support people safely. As the manager was alerted to when people's refresher training was due by reference to the matrix it was important that it contained accurate information. We spoke with the manager and the business manager about this. The business manager confirmed that the training policy and procedure was under review and they would highlight the discrepancies in recording to ensure these were dealt with as part of the review.

Equality and Diversity was part of the provider's mandatory training requirements to ensure people were cared for without discrimination and in a way that respected their differences.

Staff were happy with the training they received. One member of staff told us, "I'm happy we get enough training, the more training the better I think." Another member of staff said, "Training is ongoing all the time you get refresher training so you are always up to date with things."

The manager told us that they were delivering training over and above the provider's standard training package. These were delivered in 'bite size' sessions and a timetable of the training available was on display on the staff notice board. Topics covered included fine dining, prevention of pressure ulcers and care planning.

People's care records demonstrated how their physical, mental and social needs were assessed on admission to the home and reviewed on a regular basis. Care records contained information which took into account the advice and guidance of other health professionals when planning outcomes. For example, guidance from speech and language therapists (SALT) was used in developing eating and drinking care plans with an outcome of providing a safe diet for people who had difficulty swallowing.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

DoLS applications had been submitted appropriately and CQC had been notified of any authorisations. There was a DoLS tracker in place to alert the manager when renewal applications were due to ensure authorisations were kept up to date. Staff had been trained in mental capacity and DoLS. One member of staff told us, "You have to have DoLS in place to safeguard some people if they are not going to be safe going out on their own." Some other staff members were less confident when we asked them about this topic and the manager was looking at organising some refresher training.

We saw that capacity assessments were being done and these were decision specific. For example one person had a capacity assessment for the decision to place sensor equipment on their bed and chair. Another staff had undertaken a capacity assessment for another person in respect of their dietary requirements. We saw that where people lacked capacity to make certain decisions, best interest decisions were then being made on their behalf and the records of these decisions and the people who were involved was kept on people's care files.

Records showed staff had not been receiving regular supervision sessions and the manager confirmed this was the case. Supervision is a process, usually a meeting, by which an organisation promotes best practice and provides guidance and support to staff. The manager explained that since coming in to post they had created a new timetable for these sessions and we were shown the plan for the year ahead. Staff we spoke with felt they now received the right level of support. One member of staff told us, "I've had a few supervision meetings but I definitely get enough support. It is much better now that when I first started. There wasn't enough communication before but now it's so much better."

People were supported to maintain their health and wellbeing. People's care records contained evidence of visits and advice from a variety of professionals including community matrons, district nurses and the dietician.

One visiting health professional told us, "I have a good rapport with staff and they are always able to answer my questions. Things are being managed better recently and we are being called out a lot less." Another told us, "I have to pass on my compliments to the care staff. I have only been here on two occasions but every member of staff has really impressed me. Information is always handed over to me really well. [Staff member] has been really attentive and really listened."

People told us their health needs were met appropriately. One person told us, "If I feel poorly they always get the doctor or nurse to check me over." A relative we spoke with said, "Now the calls we get are to say our [family member] is maybe under the weather but don't worry the GP is booked and we are taking care of them. It is such a difference and our stress levels are right down now."

We spoke with the chef and observed kitchen records and audits. There was a three week menu that was changed four times a year. The chef spoke with residents individually as part of the 'resident of the day' scheme to ensure they were happy with the food they received and discuss their preferences. They had a good knowledge of people's special dietary requirements and any food that had been specially prepared was carefully labelled so that people were given the correct diet. Nobody using the service at the time of our visit required a modified diet for cultural or ethical reasons however, we were assured they would have no hesitation to cater for any such requests.

People told us they were happy with the food they received. One person told us, "I really like the food, it's always good." Another person said, "The sponge and custard was just a treat." A relative told us, "[Family member] really enjoys the food here, I have seen the food and it always looks a good standard."

We observed the mealtime experience across the whole service. Tables were appropriately set and the food looked and smelled appetising. Staff showed people plates containing the choice of meals available for lunch to help them decide which they would like. Staff were patient and attentive, provided support to those who required it and gently encouraged others. If people finished their meal, dishes containing more food were taken around the tables so people could have more if they wished. The ambience in the dining rooms was relaxed with background music being played in some areas and lots of positive interaction between people and staff.

Staff were encouraged to sit and eat their meal with people they were supporting. As an incentive staff no longer had to pay for their meals. Whilst observing lunch on the Chester unit the deputy manager explained the staff sat at tables with those people who had a poor appetite or low weight to encourage them to eat by example.

There were a small number of 'breakaway' tables that were just outside the main dining areas. The manager explained that this was to enable people to sit and enjoy a meal in a quieter environment without having to return to their room. Staff told us this was particularly useful for people who became upset or agitated by the noise or level of activity in the busy dining room.

We saw people being offered tea, coffee and snacks throughout the day. Each unit also had a drinks and snacks area where people could help themselves to the items available at any time throughout the day. There were chilled drinks dispensers containing fruit squash, crisps, fruit and baked goods such as cakes and scones. We observed people making use of these facilities during our inspection.

People's weights were monitored and food and fluid intake recorded when necessary. Records showed appropriate involvement of dieticians and the speech and language therapy team (SALT) where there were concerns regarding people's nutrition.

The environment had been adapted in some areas to make it more accessible. For example, there were handrails around the walls that were painted in a contrasting colour to make them easily visible. There was clear signage around the service clearly identifying bathrooms and toilets and memory boxes outside people's bedrooms which contained personal items to help people find their way around independently. Communal areas had dementia friendly clocks that used images to identify whether it was day or night and thereby reduce confusion in people who have a disrupted body clock. People's bedrooms were personalised and a number of people had brought in their own items of furniture. One person told us, "It is nice to bring some things from home it does make a difference. It's just like home but with a hotel feel to it!"

Good

Is the service caring?

Our findings

People told us they were happy with the staff approach and the care they received. Comments included, "I have had a hard life and the way I am looked after and treated in here makes me realise there are still good things to experience.", "There is always someone to help me and nothing is too much trouble." And "It is a lovely place to be I am so happy to be here."

Relatives also gave positive feedback. One relative told us, "My [family member] is very happy here, they keep saying how marvellous it is. The staff can't do enough for them, we are very happy." Another relative told us, "We get calls when our relative is unwell and we know they are in safe hands."

We observed positive relationships between people and staff. People were at ease in the company of staff and staff clearly knew the people they supported and their needs. There was a calm, relaxed atmosphere around the service. Staff spoke to people kindly and patiently and explained what they were doing before providing care. Interactions between staff and people who used the service were unhurried. People were given the time and support they needed at mealtimes without being rushed.

We saw visitors coming and going throughout the day. Relatives told us they were always made to feel welcome when visiting their loved ones. One relative said, "The atmosphere here is friendly and welcoming and it is comforting to leave family in such a lovely place."

Relatives felt involved in their loved one's care and thought the service kept them well informed. One relative told us, "I'm invited to meetings and feel involved in [family member's] care." Since the new manager had come into post relatives had been invited to monthly resident and relative meetings. There was a timetable of upcoming monthly meetings in the main entrance. The minutes from these meetings reflected the manager's intention to make families more involved in the service and improve communication.

Staff told us they were happy in their work and displayed a positive attitude, smiling and engaging with people using the service, visitors and colleagues.

We were shown cards and emails people's families had sent in complimenting the staff and the care their loved ones had received. One relative wrote, "Thank you all for the positive difference you made in [family member's] life" Another relative said, "Staff are excellent with the residents and I would definitely recommend it [the service]" Another relative complimented the changes that had been made to communal seating areas. They wrote, "I've noticed residents more awake and happy as they can watch people coming and going."

Staff told us how they protected people's privacy and dignity. One member of staff told us, "I close the door to give people privacy and when I'm helping to support people I talk them through everything so they understand what's happening and don't get frightened. That's the respectful thing to do." We observed staff providing care in a polite and courteous way. Staff knocked on people's bedroom doors and waited for

permission before entering. One person told us, "It is not nice having to depend on others for personal care but they do it so professionally it takes away the embarrassment." A relative told us, "Some [staff] are exceptionally good, one carer actually came in on their day off to get [family member] ready for my [relative's] funeral. They are always very respectful when providing personal care and always seek permission and close the door."

People were supported to remain as independent as possible. Staff told us how they encouraged people to maintain their independence. One member of staff said, "If someone has a wheelchair they can sometimes get used to using it all the time. If they can walk shorter distances we encourage them to do that. It's important to keep them mobile for as long as possible."

We asked staff how they ensured people's different needs were addressed. For example in respect of their age, disability, gender, religion or belief. One member of staff told us "Equality and diversity is about knowing about someone. It is important to take time to chat with people and learn about what is important to them. That way we can be sure we meet their needs." Holy Communion was delivered every week to those who wished to participate and other church groups visited the service to ensure people's religious needs were met.

The manager told us nobody was using the services of an advocate at the time of our inspection. They had sourced information about advocacy support from local agencies and was obtaining further literature and leaflets about this so the information was readily available to people. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions.

Good

Is the service responsive?

Our findings

People told us they received care that was tailored to meet their individual needs. Comments from people included, "I can choose my food, clothes, whether or not I have a shower or bath and if I want to stay in bed all day that's fine as well!", "I can sleep when I want, eat in my room and listen to music or go and find someone to chat with – I have made loads of friends here. I feel free." And, "The staff take trouble to find out what I like and dislike."

Choice was embedded in the ethos of the service and apparent in our observation of staff interaction. We heard staff regularly using terms such as, "Would you like?", "Do you want?" and "Is this ok?"

Care plans contained personalised information to help staff support people as individuals in a way that suited them best. Staff demonstrated a good knowledge of the people they supported and they were able to describe to us how a person's care should be provided in a way that reflected what we had seen in their care plans. Detailed life history information had been completed in conjunction with families and we saw staff adding to these when they had discovered more information during conversation.

People told us they were happy with the level of activity available and felt they were given a variety of options when it came to social engagement. One person told us, "There are loads of things happening here, it's pretty hectic sometimes with singing and bingo and so many other things going on. What's not to like?" Another person told us, "The activity lady is brilliant she tries hard to involve everyone and we are asked for suggestions as well." A relative said that although his family member was not always wanting to join in things they had their hair done and had one to one chats with staff.

The provider employed three part-time members of staff to oversee and coordinate activities within the service. These staff were referred to as the lifestyle team. The service was a member of the national activity provider's association (NAPA) and the manager told us they felt meaningful activity was everybody's role and responsibility and was not to be left solely to staff on the lifestyle team. Although activities took place throughout the service there was also a dedicated lifestyle room called 'The Meadows'. This area was accessible for anyone who wished to use it and contained a variety of things for people's entertainment such as arts and crafts equipment and books. A pub lunch club had been started and a small group of people were attending a local pub every week.

The provider had a complaints procedure in place and this was clearly displayed in a communal area. The manager talked us through the way complaints were dealt with and explained that all concerns raised were handled in line with the complaints policy. We saw records of the complaints and concerns received and the communication from the manager detailing the outcome of the complaint. Regular meetings were being held with families where concerns had been raised to ensure they continued to be happy with the progress that had been made.

People and their relatives told us they knew how to make a complaint if necessary. One person told us, "I know for sure I would not need to complain, it is much nicer to just have a chat." Another person said, "No

point in complaining when the manager is known to everyone and always wandering around chatting to residents." A relative we spoke with said, "The manager and all the staff have an 'open door' policy so I would pop in and have a chat and sort things out there and then."

Care plans were in place which recorded people's end of life wishes and staff had received training in this area. Where people had do not attempt cardiopulmonary resuscitation (DNAR) orders in place these were filed in a prominent location and kept under review to ensure that people's wishes were observed.

Good

Is the service well-led?

Our findings

One relative told us, "There has been a great improvement from when [family member] first came here. There has been a change in management and things have improved considerably, everybody is more approachable." Another relative said, "Things have got much better. The new manager is very approachable. They are always around, it's a vast difference."

At our last inspection we found that effective audit systems were not in place. This was a continuing breach of our regulations. We took action by requiring the provider to send us action plans setting out how they would address this issue. During this inspection we found improvements had been made. The provider was no longer in breach of regulation.

The provider had an annual program of monthly audits which were completed by the manager. Data from these audits was collated and analysed to identify potential areas for development or improvement. Although audits had not identified every issue we found, specifically around medicines, the manager made changes to audits immediately in light of feedback give throughout the inspection to ensure they were even more robust going forward.

The manager was supported by a regional director, operations director and business manager. There were regular visits from this senior management team to provide support to the new manager whilst they became more familiar with the role.

Records we looked at contained accurate and up to date information relating to people's care needs.

Staff were regularly consulted and kept up to date with information about the home and the provider. An annual staff survey was undertaken and action plan drawn up describing the ways in which feedback is being acted on. Staff meetings were taking place every two months. We saw minutes of recent meetings that covered topics such as people's personal care needs, introduction of 'bite-size' training sessions, staff holidays and rotas. Staff told us they were happy with the frequency of meetings and felt able to approach the manager between meetings if they had anything they wished to discuss. Staff told us they felt listened to if they made any suggestions. One member of staff said, "I think the meetings are a great opportunity to discuss stuff. Things have changed because of things we have said."

We observed management and staff to have a good rapport. There was a professional atmosphere but there was also laughter and relaxed 'banter' between colleagues. One member of told us, "We feel we can laugh now and that makes such a difference. The staff are so much happier and that rubs off on the people we care for."

One member of staff told us, "[Manager] and [deputy manager] are very approachable. They are constantly checking that I'm ok. I definitely don't feel I've been dumped in at the deep end. They've been happy to answer any questions I've had." Another member of staff said, "The new manager works with us not against us. We are all part of one team." A third member of staff said, "The new manager is a breath of fresh air."

A night manager had been appointed in October 2017 to ensure that staff who worked night shifts also had regular access to a member of the management team for things such team meetings as supervision.

The manager had a very clear vision of the ways in which they wished to enhance the environment in in a dementia friendly way and had taken steps to engage a consultant to provide advice and quotations for this. The manager had entered their plans into a competition held by the provider in an attempt to secure some of the funding needed for this project.

Staff spoke very highly of the manager. One member of staff told us, "[Manager] is so lovely I wish they'd been the manager before and I'm glad [Name] is the deputy now. I think they'll be good for the home." Another member of staff said, "[Manager] is always available if I need to discuss anything."

The manager had introduced a suggestion box as another way of obtaining feedback. This was placed in a communal area by the main entrance so that people using the service, visitors and staff all had easy access to it. A 'decision tree' was also in use and was seen on display in the service. This was a small tree on which people had hung tags on which they had written their response to a particular question. At the time of our visit the manager was using this method to ask people to choose between two events that would be the basis for a forthcoming celebration.

People who used the service and their relatives were given the opportunity to participate in satisfaction surveys. People were given questionnaires and relatives were also contacted by telephone. We saw the results had been reviewed and analysed and an action plan was being produced in response to the comments made. One person told us, "I have completed a questionnaire and on it I was asked to suggest improvements. It is so good here I couldn't think of anything!"

A staff award scheme called GEM was in operation. This was to recognise where staff had 'gone the extra mile' and people using the service were encouraged to nominate a member of staff who they felt deserved this recognition. The award was given each month and people were invited to be involved in a little award ceremony.

The service had close links with healthcare professionals such as the community matron, district nurses, occupational therapists and the Intensive Community Liaison Service (ICLS). ICLS offer assessment and interventions for people who display behaviours that challenge. One health professional we spoke with told us, "The manager has been very supportive. They are always attentive and I am confident they really listen to me. I feel like they treat me with respect." Another told us, "I have definitely seen an improvement since the new manager was appointed, staff morale is much better. This is a big home so we are here daily and have definitely seen positive changes."

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.