Rushcliffe Care Limited

Normanton Village View Nursing Home

Inspection report

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Date of inspection visit:
11 December 2018

Date of publication:
27 February 2019

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

This inspection took place on 11 December 2018 and was unannounced. At our last inspection of the service in March 2018, the service was rated as Requires Improvement. We found the provider's arrangements for assessing risks for people were not always completed, medicines were not always administered safely and systems to monitor the quality of the service provided were not always effective. There were breaches of Regulations 12 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions to at least good. At this inspection, we found that improvements made were sufficient to rectify the breaches and the overall rating has improved to Good.

Normanton Village View Nursing Home 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.

The service accommodates up to 72 people across four separate units, each of which have separate adapted facilities. The service specialises in providing care to people living with dementia with varying dependency needs. At the time of our inspection there were 43 people using the service, and three of the four units were in use.

There were two registered managers in post who shared responsibility for the service. 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.

Records and observations of care provided did not support there were always enough staff deployed in the service to provide people's care in a timely manner. Following our inspection, the registered manager told us they were developing a staff dependency tool to enable them to ensure sufficient staff were always deployed across the service to meet people's needs.

Staff had a good understanding of their role in keeping people safe and protecting people from the risk of abuse. Risk assessments were in place and regularly reviewed to manage potential risks within people's lives, whilst also supporting their independence. Accidents and incidents were analysed to ensure lessons were learnt to reduce the risk of future harm for people.

Staff recruitment procedures ensured that appropriate pre-employment checks were carried out so only suitable staff worked at the service.

Medicines were managed and administered safely and as prescribed. Staff followed safe infection control procedures to protect people from the risk of acquiring health related infections.

Staff induction training and on-going development training was provided to ensure they had the skills, knowledge and support they needed to perform their roles. Specialist training was provided to make sure that people's needs were met. Staff were well supported by line managers and had regular one-to-one supervisions.

People's needs were assessed to ensure care provided met with their needs and they were supported to maintain their health and well-being. People who were at risk of poor nutrition, were supported to ensure they had sufficient amounts to eat and drink. People and relatives were positive about the quality of the meals provided.

People's consent was gained before any care was provided. People were supported to have maximum control and choices of their lives and staff supported them in the least restrictive way possible.

Staff treated people with kindness, dignity and respect and spent time getting to know them and their specific needs and wishes. Care plans reflected people's likes and dislikes and staff were knowledgeable about people's preferences.

People and relatives were involved in care planning and were able to contribute to the way in which they were supported. This supported personalised. Care plans were regularly reviewed and updated to ensure the care provided met people's needs.

People were supported to engage in meaningful, stimulating activities and could choose how they spent their time.

A process was in place which ensured people could raise any complaints or concerns. Concerns were acted upon promptly and lessons were learned through positive communication.

Significant improvements were made for the management and oversight of the service and to the provider's arrangements to check the quality and safety of people's care. People, relatives and external authorities had increased confidence in the management of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider did not use a robust, systematic approach to determine the number of staff and range of skills required to meet people's needs and keep them safe at all times.

There had been improvements in assessing people's risk of harm and these were reviewed regularly.

There were processes in place to ensure people's medicines were managed safely.

Staff were knowledgeable about the measures they needed to take to keep people safe.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to undertake their roles and responsibilities.

People were supported to maintain and improve their health and nutrition in consultation with external health professionals when required.

Staff sought people's consent or appropriate authorisation for their care.

Is the service caring?

Good

The service was caring.

There was good communication between people and staff. Staff had sufficient knowledge about people to provide them with the care they preferred.

People and their relatives were involved in planning and reviewing their care.

Staff were respectful to people and protected their right to

privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People's care plans were regularly reviewed and updated to reflect people's changing needs.

People were supported to engage in meaningful, stimulating activities.

People and relatives were confident to raise concerns and complaints and action taken to make improvements.

Is the service well-led?

Good

The service was well-led.

There was an effective quality assurance audit process in place to measure the quality of the service.

People, relatives and staff were kept up to date and consulted about developments within the service.

The provider had systems in place to encourage continued improvement and development of the service.

Normanton Village View Nursing 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014

This inspection took place on 11 December 2018 and was unannounced.

The inspection team consisted of two inspectors, a Specialist Advisor, who was a registered nurse, 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.

The provider had not been sent a Provider Information Return. This is a form that they complete annually and provides key information about the service, what they did well and any improvements they planned to make. We provided the opportunity for senior staff to share this information during the inspection visit. We reviewed information we held about the service, including notifications. A notification is information about important events which the provider is required to send us by law. We spoke with local authority care commissioners and health agencies responsible for commissioning, monitoring and reviewing the care of people using the service.

During the inspection we spoke with 16 people who used the service, five people's relatives and a visitor. We spoke with both registered managers, a senior manager, 11 members of the care and nursing staff team, a housekeeper and an activity co-ordinator. We observed care and support being delivered in the communal areas. We also observed meal times to understand people's dining experience and the support they received to eat and drink.

We reviewed six people's care plans and daily records to see how their care was planned, delivered and

reviewed. We also looked at other records relating to how the service was managed, for example, staff recruitment, training and rotas, medicines records and checks of quality and safety.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2018, we rated the service as requires improvement in the safe domain. This was because risk assessments were not always completed to meet the needs and safety of people and medicines were not always administered safely. These were breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection, the provider told us about the action they were taking to rectify the breaches. At this inspection we found that sufficient improvements had been made to rectify these breaches.

People's risk of harm had been identified, assessed and where necessary acted upon. Risk assessments were detailed, individualised and up to date. They covered all the potential risks present for people and the environments they were receiving support in. For example, one person required hoist support to transfer and needed to sit in a specific recliner chair with a pressure cushion to protect the integrity of their skin. We observed staff followed this guidance when supporting the person to sit in a communal lounge. A second person had been assessed as being at risk from falling out of bed. Records showed this risk had been assessed, options to reduce the risk considered, and action taken to keep the person safe.

Staff demonstrated they were knowledgeable about the risks each person faced and knew what to do to keep people safe. We saw staff supported people to move around the service safely and ensured people's mobility aids, such as walking frames, were close by them. Staff used equipment safely, providing reassurance to people during transfers and ensured people were safe and comfortable when seated.

Improvements had been made to records where people required support to move their position. Records detailed frequency of support and equipment to be used, for example profile beds and pressure relief mattress. Monitoring records showed staff recorded times people had received support to change their position and what the position had been changed to. Times of support mostly correlated to guidance within risk assessments, though we found occasional gaps in records where support had not been recorded in line with recommended frequency times. The registered manager was working with staff to ensure records were completed accurately and consistently.

Information was available to protect people in the event of an emergency within the service. Personal emergency evacuation plans were place for each person in the event of an emergency, such as a fire. The plans were reviewed regularly and were coded to reflect people's level of mobility and indicate the support they would require to leave the building or area safely.

Care plans included detailed guidance for staff to support people who could demonstrate behaviours that were challenging. For example, records detailed possible triggers that may contribute to a person feeling anxious or distressed and suggested interventions from staff. Throughout our inspection, we observed staff were quick to respond to people when they became distressed and were skilled at reducing people's anxiety.

People received their medicines safely and as prescribed. People told us they had no concerns with the

support provided by staff and we observed staff were patient and consulted with people before supporting them to take their medicines. A small number of people received their medicines covertly (disguised in food or drink) and we saw these were supported by clear protocols detailing how these were to be administered. These guidelines were followed by staff. Medicines were stored safely and medicines administration records (MAR) were filled in accurately. MAR were supported by a one-page profile which detailed the person's preferred method of administration, compliance and allergies. Topical medicines, such as creams and lotions, were supported by body maps to support staff to administer them to the correct area and transdermal medicines, such as skin patches, were supported by rotation and monitoring charts. We saw one person declined to take their medicines. Staff respected this choice and told the person they would ask again in a little while. The person consented to taking their medicines at the second attempt. This demonstrated staff followed guidance in people's care plans and respected people's right to make decisions and choices about their medicines.

Medicines were administered by nursing staff who had completed the training needed to support people to take their medicines safely. The registered manager was in the process of enabling senior care staff to undertake training in the safe administration of medicines to reduce the workload of nursing staff. One nurse told us, "We really rely on [care staff] a lot and having help with medication is invaluable; especially when people's needs change and our skills are required elsewhere."

People told us they felt safe using the service and this was confirmed by relatives and visitors we spoke with. People's comments included, "I'm not scared or frightened. I don't worry about anything," and "I feel safe here. I have my walking frame and staff help me." Relatives told us, "[Name] is safe here because they have a crash mat at each side of their bed. Staff have given [Name] a special type of chair which prevents [name] from falling. They [staff] always ring me up if something happens, like when [Name] banged their head," and "[Name] has been poorly and staff are monitoring everything to make sure [Name] is safe. I am involved in [Name] care plan and following each fall they [staff] review the risk assessment."

People told us they felt there were enough staff to meet their needs, but relatives provided mixed views. Relative comments included, "Sometimes there are not enough staff on duty but there is always plenty of staff at lunchtime," "I think there are enough staff. When I visit I see staff in the lounge most of the time," and "There seems to be enough staff, they have time to sit and chat with people. They don't just dash about doing tasks but just sit and listen." Staff also provided mixed views as to whether there were enough staff to meet people needs.

During our inspection we saw that staff were attentive to people and spent time providing reassurance and the care and support they needed. However, we also saw two occasions when people had to wait for staff support because staff were busy. For example, in one unit, two people required support with their personal care needs, however only one care staff was available at that time. People were asked to wait for a second member of staff to arrive, some ten minutes later, to assist. In the meantime, both people had experienced a loss of dignity.

We reviewed staffing rotas from 19 November to 9 December 2018. The registered manager had identified a total number of day care staff required to meet people's needs as eleven. Records showed that actual numbers had fallen below this requirement on several occasions, although on other occasions the actual numbers of care staff had exceeded the required number. There was no explanation for this fluctuation in staffing numbers. The provider did not use any formal dependency tool to demonstrate they used a robust, systematic approach to determine the number of staff and range of skills required to meet people's needs and keep them safe at all times. However, the registered manager had undertaken individual dependency assessments for people and determined the number of staff required from collating this information.

Following our inspection, the registered manager provided us with details of a proposed dependency tool they intended to implement within the service. They told us they would review staffing levels at the service to ensure there were always sufficient numbers of staff to meet people's needs.

People were protected from the risk of abuse because staff demonstrated they were aware of and understood procedures for identifying and reporting any suspected or witnessed abuse. Staff told us and records confirmed they had completed training in safeguarding and this was regularly refreshed. People and relatives were confident to raise any concerns they may have in relation to people's safety. The registered manager displayed safeguarding information on communal noticeboards throughout the service to raise people and visitors awareness of abuse and support staff understanding of their role in protecting people. The provider's written procedures provided people with information to raise concerns and included contact details for external agencies concerned with protecting people's safety if they needed to. The registered manager had made appropriate notifications and worked with external agencies to ensure actions were taken to keep people safe.

The provider's recruitment procedures helped to ensure only staff who were suitable to work in care and support services were employed. New staff did not provide care to people until full employment checks had been carried out. For example, identity and employment checks and a check with the Disclosure and Barring Service (DBS). One staff member told us, "They [provider] did my DBS and got my references back before I was allowed to start."

People were protected by the prevention and control of infection. People were cared for in a clean and tidy environment. During our inspection, we saw staff were available to clean people's rooms, bathrooms and communal areas. Staff were trained in infection control and appropriate personal protective was available for staff to use, for instance gloves and aprons. Hand wash basins were not available in some people's rooms. The provider had ensured hand sanitisers were available for people and staff to use.

The provider was maintaining records of accidents and incidents which occurred in the service. Staff gave us examples of what they would report. We saw the registered manager monitored and analysed accidents and incidents to identify any trends or patterns which could be used to prevent future harm. For example, safeguarding incidents were discussed in appropriate forums and lessons learnt identified, such as falls prevention and staff intervention.

Good

Is the service effective?

Our findings

People told us they were happy living at Normanton Village View Nursing Home and people and relatives were complimentary about the staff and the service. People's comments included, "The staff look after me, they are good," and "They [staff] know what they are doing; they look after you like a human being." Relative comments included, "I think the staff know what they are doing," and "They [staff] are the next best thing to me looking after [Name]. The staff are monitoring [Name] health needs following recent changes. The registered manager keeps me informed and involved in any changes."

People's needs were assessed to achieve effective outcomes, and care and treatment was delivered in line with best practice and up to date guidance. For example, nursing staff demonstrated a good awareness of National Institute for Health Care and Excellence (NICE) clinical guidance. We saw that detailed pre-assessments of people's needs were created by management before care was delivered. This helped to ensure each person's needs could be met. The registered manager oversaw all referrals and assessments to the service and told us they were clear on the level of needs they were able to support in the service, including compatibility with other people using the service. Processes were in place to identify people's diverse needs, and ensure that no discrimination took place. Staff we spoke with were trained and knowledgeable in how to support people with a wide range of preferences and needs.

Staff were skilled, knowledgeable and experienced in providing people with the care they needed. All staff went through an induction training package when starting employment, and continued training to refresh knowledge and keep up to date with care standards. The provider's training matrix, a central record of training staff had completed, showed staff had access to a range of mandatory and specialist training to meet people's needs and this was kept up to date. One staff member said, "Although I worked in care before, I still had an induction when I started here. I worked with experienced staff for a few days to get to know people and the home. It was useful." Training included subjects such as safeguarding, infection control, dignity through action, equality and diversity and dementia care. Nursing staff were supported to maintain their clinical knowledge and skills through on-going training.

Although staff demonstrated a good understanding of dementia care, many staff were unable to describe the impact the provider's training had had on their existing knowledge and experience. Instead, they referred to training and experience gained prior to working in the service. Training in dementia care was provided on-line, as were other modules of training. Following our discussions around reviewing the impact of dementia care training for staff, the registered manager contacted us to inform us of new proposals for more advanced dementia training for staff following the provider review of the current provision. This would help to ensure staff had a consistent understanding and application of care for people living with dementia.

Staff told us they felt supported by the management of the service and felt the atmosphere in the service had improved through recent changes in management and structures. Nursing staff spoke about the support they received from the registered manager, and from care staff. Care staff spoke of positive line manager relations and feeling supported to work as a team. Staff told us they received regular supervision where they could discuss targets, achievements and development needs with their line manager.

People were supported to maintain good nutrition. People were positive about the food provided and said they enjoyed their meals. People's comments included, "The food is excellent and the girls in the canteen do an excellent job," and "The food is pretty good overall." People told us drinks were readily available and they were served with their preferred beverages. We saw drink and snack stations were stocked and available and people were offered drinks and snacks throughout the day.

Menu planning took place and people were offered a choice of food from pictorial information. At lunchtime, people's choices were further supported by staff showing them two plated meals to choose from and helping people to choose drinks by colour. We observed that lunch took place in a relaxed and comfortable atmosphere, with people choosing to eat in dining areas or their own rooms. Tables were nicely laid out, but we noted there were no condiments on the table in one dining area. When we asked staff, they told us they didn't put these on the table as people may harm themselves. Staff told us they offered these but we did not observe this. Indeed, condiment containers that were kept in a cupboard were dirty and unhygienic. We raised this with the registered manager who told us they would act to address this.

Some people had difficulty eating and drinking because of their health condition. Where this occurred, staff ensured people were provided with the support they needed and the correct consistency of food and drink. For example, if people had difficulty swallowing, staff thickened drinks and provided pureed or soft diet and ensured seating arrangements were in line with health guidance in people's care plans. Staff were attentive to people's needs. For instance, we saw staff supported people to eat at their own pace, consulting with them as to what and how much they wanted to eat. Where people declined their meals, staff encouraged them to take alternative choices to ensure they had sufficient amounts to eat.

People's care plans included an assessment to identify if they were at risk of poor nutrition. Assessments included guidance for staff to observe the potential signs of dehydration and people were weighed regularly. Action was taken where concerns were identified, such as loss of weight, through referrals to the GP. Staff maintained records of people's daily fluid and food intake to support effective monitoring of people's nutritional needs.

People were supported to maintain and, if possible, improve their health and well-being. Records showed staff consulted with a range of external health professionals and followed their instructions for people's care. For example, dieticians, physiotherapists, falls prevention and GP's. People were supported to access routine appointments, such as chiropody, in addition to specialist health professionals. Detailed wound management plans were in place where people were vulnerable from poor skin integrity. We saw records were detailed and supported the effective management of wound care.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. Records confirmed assessments of people's mental capacity had been undertaken. Care plans detailed

the support people needed to make day to day decisions and choices, such as what to wear and how they spent their time, and processes for more complex decisions. Where people required DoLS authorisations, for example, due to continuous supervision, these were in place or had been applied for. Records highlighted when applications had been made, any conditions and the next review date from when an authorisation had been granted. Where representatives or relatives had Lasting Power of Attorney (LPA) to enable them to make decisions in people's best interests, these were evidenced in people's care plans. DNAR (Do not attempt Resuscitation) forms had been completed with people or through best interest processes and were signed and dated for review, where appropriate.

We observed staff sought consent before providing care and support. For example, staff asked before they supported people to mobilise and if they were happy to have assistance with personal care. Where people declined care and support, for example medicines or meals, staff respected this and tried alternative approaches. This included giving people time, or an alternative staff member approaching the person. if the person continued to decline, staff respected this choice and ensured the decision was documented. A staff member told us, "DoLS is there for us to look after people and keep them safe. The person may not know, for example, they could be unsafe if they went out on their own."

The provider and registered manager had continued to make improvements to the décor of the premises. This included layout of communal lounges to ensure there was sufficient space for people to move around in and signage to guide people and visitors around the building and to key areas, such as rooms and toilets. We saw people were able to walk freely along corridors and in communal areas where they wished to. People were encouraged to personalise their rooms and lounges were homely and inviting. Although there were a variety of stimulating pictures on walls, there was little in one unit to provide distractions or points of interests for people on route around communal areas. The registered manager told us they were working on developing appropriate stimulation, dependent on people's needs and responses.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind, caring and supported them well. Comments included, "It's friendly on all levels. The staff are not 'slip-shod'. a positive eye opener," "The staff are caring and have a good understanding of people's needs. Staff use the person's name when they talk to them. They have time to sit and chat," and "The staff are wonderful, so caring and kind. They seem to have so much patience."

We saw staff were kind and compassionate to people. People looked relaxed and at ease in the presence of staff and we heard laughter and banter between them. Staff told us they were pleased they had time to spend with people whilst also providing care.

We saw good communication between people and staff throughout our inspection. Staff took time to listen to people and when they received repetitive requests, they responded with patience and interest. Staff were attentive to people who had limited verbal communication and took time to provide appropriate physical contact and reassurance, such as hand holding. We saw people responded positively to this. Staff constantly checked that people were okay and we heard supportive comments such as, "Can I help you with that?" and "How are you today?" We observed staff explaining what they were going to do and ensuring people were happy for them to continue. For example, staff consulted with a person as to where they wanted to sit.

People's care plans were written in a way that reflected their personal preferences, likes and dislikes. People and their relatives told us they were involved and consulted in the care provided. Records showed people and relatives were able to feedback and review the care provided, and make changes as they required. Relatives told us they felt staff took the time to get to know people and felt consulted and involved, particularly in changes to people's care. Staff were aware how people preferred their care to be delivered and how they liked to spend their time. For example, for one person, it was important to carry an object of comfort with them at all times. We saw staff ensured they had this with them, including it in meal times and in conversations. This brought comfort for the person. A second person liked to converse in their first language, which was not English. Staff had learnt basic words in the person's first language and some staff were able to converse fluently with the person. Staff also demonstrated good awareness of the person's cultural needs and their traditional views, observing these when interacting with the person.

The registered manager provided information about advocacy services on notice boards for people and visitors. An advocate is an independent person who can support people to ensure their views and opinions are heard and taken into account regarding choices and decisions.

Relatives told us they were free to visit at any time and we observed visitors were greeted warmly by staff. Some relatives chose to have a drink or a meal with their family member and this was supported and encouraged by staff.

People confirmed staff respected their privacy and dignity when providing care. During our inspection, we saw that staff were considerate when entering people rooms. They knocked on doors before entering and were aware of protecting people's dignity when personal care was provided. Staff were attentive in

preserving people's dignity when in communal areas, such as asking people if they could adjust their clothing to ensure they were appropriately covered at all times. Staff spoke respectfully with people and used people's names or preferred titles when addressing people or referring to them. The registered manager had displayed key information about dignity which helped to raise people, visitors and staff awareness of people's rights. Many staff had completed additional training to become dignity champions, which helped to instil these values throughout staff working practices.

People were enabled to maintain their independence as much as possible. For example, staff encouraged people to hold their own spoon or fork with hand over hand guidance rather than simply doing this for people. People were encouraged to walk about and maintain their mobility and independence where they were able to.

Staff demonstrated they understood the need for confidentiality and were considerate that personal information was not shared with people inappropriately. Records were mostly held electronically which staff accessed through mobile phone devices or laptops. These were encrypted and password protected to ensure people's data was stored and used in line with legal requirements. Manual records were securely stored in designate areas.

Good

Is the service responsive?

Our findings

Care and support was personalised to meet each person's individual needs. People we spoke with told us that staff knew them well and understood their needs. Relatives described how staff involved them in people's care and listened to them during the assessment process and when care was reviewed. One relative told us, "They [Name] were assessed before they moved in here. I think it was to make sure they would be okay here."

Care plans contained a personal history about the person, as well as likes, dislikes and preferences. This enabled staff to better understand the experiences of each person and their social and emotional support requirements. For example, care plans included how people expressed themselves during different situations and guided staff on the most appropriate response. Cultural and religious information was included when relevant for each person. For instance, their preferred language or cultural needs that should be observed. Staff demonstrated a good understanding of people's backgrounds, needs and preferences. They told us the electronic care planning systems, used by the provider, made it easy to find out information about people quickly and understand what their preferences were.

People's care was regularly reviewed to ensure it met their current needs. One person told us, "There are records about me. We talk about these. I am happy with everything." A relative told us, "I have attended [Name] review. I think the staff do take into consideration what I say." Records we looked at confirmed people's care and care plans were evaluated monthly or earlier if a change occurred. The registered manager had introduced a 'Resident of Day' which focussed on the person and reviewed all aspects of their care in the detail. This helped to ensure records reflected people's needs and supported staff consistency to provide care in line with people's wishes.

People were supported to access and engage in meaningful activities which offered stimulation and interaction. A member of staff responsible for co-ordinating activities within the service described how they used people's care plans to evaluate and monitor activities provided. For example, one person had limited hand movements. Staff had successfully engaged them in painting by the person holding the paint brush and the staff member moving the paper. Sensory blankets were used to engage with people and sessions were also held one-to-one with people where they chose not to participate in group sessions. For example, music and movement. Staff told us people had photograph albums and these were used in reminiscence. For instance, one person had previously enjoyed holidays overseas. Staff played music of beach and seagulls whilst looking through past holiday photographs to support the person's memories. The activity co-ordinator had made links with local schools, pubs and churches to enable people to visit and to bring services in for people to enjoy.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. This is a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given.

Care plans detailed how people preferred to receive their information. This could be verbally, in a written format, in their first language or through a representative, such as a family member. Information was displayed on communal notice boards in eye catching formats to support people and visitors awareness of key policies and people's rights in how care was provided.

People and relatives knew how to make a complaint or raise concerns and were confident that their concerns would be listened to and acted upon as required. One relative told us, "I have never seen anything to give me concerns on my visits. If I did, I would talk to the [registered] manager or contact Care Quality Commission." A second relative described how they had concerns about a proposed change for their family member. They told us they felt the registered manager listened to their concerns, took action to provide assurance and the changes had proved to be for the benefit of their family member.

There was a policy in place for receiving complaints and a set process to follow which meant complaints were investigated and responded to within a set time period. The registered manager used complaints to bring about improvements within the service. For example, a complaint about a person's care had resulted in improvements to the care plan review process overall. Records showed improvements were reviewed to ensure they remained effective in reducing the risk of further concerns.

People were supported to make decisions and choices about their end of life care. Records showed staff provided the care people wished where end of life care had been identified. For example, one person's end of life care plan detailed the measures staff needed to take to reduce the person's pain. This included detailed guidance for supporting the person and specific use of anticipatory (end of life) medicines. Staff were trained and knowledgeable in providing end of life care. The registered manager had supported one experienced staff member to be a lead on promoting excellence in end of life care, including liaising with staff to promote best practice. This had resulted in positive outcomes for people and their relatives. Staff involved relatives and friends, where appropriate, and worked with other health care professionals also involved in providing end of life. This combined approach helped to ensure people were treated with dignity and respect.

Good

Is the service well-led?

Our findings

At our last inspection in March 2018, we rated the service as requires improvement in the well-led domain. This was because the provider had systems and processes in place to monitor the quality of the service, but these were not always effective in improving the quality of the care provided. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider told us about the action they were taking to rectify the breaches. At this inspection we found that improvements had been made to rectify this breach.

Comprehensive quality assurance systems were in place to monitor all aspects of the service. The registered manager undertook detailed audits of people's care plans and records and nursing staff supported regular auditing of areas such as clinical care, infection control, work practices and health and safety. Records showed where issues were found, actions were set to make improvements. For example, improvements in information and guidance within people's care records, increase in daily checks of equipment such as pressure relief mattresses and ensuring settings were accurate. The registered manager was supported by senior managers who also undertook independent audits and checks to ensure the registered manager's audits were an accurate reflection of the quality provided and provide additional feedback. Reports were developed to capture information about the quality of the service which was being provided and these were discussed with the provider and senior managers. This helped to ensure people received good care and the provider was compliant with relevant legislation.

There were two registered managers' in post who shared responsibilities. One registered manager oversaw all aspects of the day-to-day running of the service and management of staff, and had been responsible for many of the improvements we found. The second registered manager oversaw the quality of the service and represented the provider in undertaking the provider's quality assurance visits to the service to ensure compliance.

People, relatives and staff we spoke with told us the registered manager and provider had been open and honest with them about the previous inspections and the concerns that had been raised about the quality of care. One relative told us, "There was a meeting where they [registered manager] told us everything. They didn't hide anything. Over the last 12-18 months there have been many positive changes. The registered manager is good because they listen to me. I rate here as nine out of ten." People and relatives spoke positively about the service. Comments included, "I have no experience of care homes, but if they are all like this it's excellent. I find I have nothing to worry about. The person in charge [registered manager] is great, we are good friends already," and "Before this [registered manager] they [provider] were in Special Measures. The registered manager is turning it around. The staff are open and transparent and tell us things. I would give it nine out of ten."

People and their relatives confirmed they were able to share their views through meetings, satisfaction surveys and face-to-face with the registered manager through regular open clinics. Minutes from a meeting held in August 2018 demonstrated people were provided with information, such as changes and developments within the service, and supported to share their views. The registered manager was in the

process of developing a 'you said, we did' format to capture people's views and show people how these were used to drive improvements in the service. We saw people smiled as the registered manager approached them and looked at ease in their company.

Staff spoke positively about working as a team, which had been encouraged and facilitated by the registered manager. Senior care staff were involved in key decisions, such as staff recruitment. They told us this was effective as they knew what skills were needed and helped to develop a positive, rounded team. The registered manager held daily meetings with senior staff from all areas. This supported senior staff to share information and identify any issues that required the team to action. Staff generally spoke positively about the registered manager and told us the changes since the last inspection had improved staff morale, supported respect amongst the staff team and improved the care provided. The registered manager made themselves accessible to staff and provided guidance where required. Staff meetings were used to consult with staff, provide information and remind staff about best practice and the importance of following the provider's policies.

The service worked positively with outside agencies. This included holding strategy meetings where appropriate and liaising with local authorities, health commissioners and safeguarding teams. The registered manager had forged links with key partners to ensure the service provided was in line with best practice and local commissioning strategies. Local authority commissioners were positive about the service.

The latest CQC inspection report rating was on display at the service and on the provider's website. The display of the rating is a legal requirement to inform people, those seeking information about the service and visitors of our judgements.