Ash Sharma Sunjay Rai

Rivendale Lodge EMI Care Home

Inspection report

14 Prideaux Road
Eastbourne
East Sussex
BN21 2NB

Tel: 01323731575
Website: www.rivendalelodge.co.uk

Date of inspection visit:
08 October 2018
09 October 2018

Date of publication:
19 November 2018

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?	Requires Improvement

Summary of findings

Overall summary

Rivendale Lodge EMI Care 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. Rivendale Lodge provides accommodation for up to 27 older people, some of who were living with dementia, in one adapted building. At the time of the inspection there were 25 people living at the home.

We inspected Rivendale Lodge on 8 and 9 October 2018. The first day of the inspection was unannounced, this meant staff did not know we were coming. We had previously carried out an inspection in June 2015 where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We returned in August 2016 where we found that some improvements had been made however there were still some breaches in regulation. We inspected the home again in August 2017 where we found there was a breach of regulations remained. This was because people's records were not consistent and did not contain all the information staff needed. This had not been identified through the quality assurance system. We also found that where people did not have the capacity to consent, the registered person had not always acted in accordance with legal requirements.

We served a warning notice as part of our enforcement process in relation to people's records. We also met with the provider to confirm what they would do and by when to improve the key questions of effective and well-led to at least good. The provider sent us an action plan and told us they would address these issues by December 2017. At this inspection we found improvements had been made and the provider was now meeting the regulations. However, further time was needed to ensure improvement and changes made to people's records and the quality assurance system are embedded into every day practice.

There was a registered manager at 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.

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 were looked after by staff who were kind and caring. They treated people with dignity and respect. Staff were committed to promoting people's independence, supporting them to make choices and enjoying themselves. Staff ensured care and support was provided in a way that met people's individual needs and wishes. Staff knew people well and understood their care and support needs. There was an activity programme which people enjoyed participating in as they wished. This was adapted to suit people's individual needs.

The registered manager was well thought of by people, relatives and staff. They were supportive to people

and staff. They had a good understanding of what was needed to improve and develop the service. Systems were in place to gather feedback from people and staff and this was used to improve the service. Complaints had been recorded, investigated and responded to appropriately.

Staff had a good understanding of the risks associated with the people they looked after. Risk assessments were in place and provided the guidance staff needed. Staff understood how to safeguard people from the risk of abuse and discrimination. They were aware of their own responsibilities and what steps to take if they believed someone was at risk.

There were systems for the safe management of medicines. People were supported to receive their medicines in a way that met their individual needs and preferences. Only care staff who had received training on medicines gave them.

There were enough staff working to provide the care and support that people needed. Recruitment procedures ensured only suitable staff worked at the home. There was a training programme for staff and they received regular supervision.

People were supported to eat and drink a choice of food that met their individual needs and preferences. People's health and well-being needs were met. They were supported to have access to healthcare services when they needed them.

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.

Staff had a good understanding of the risks associated with the people they looked after. Risk assessments were in place and provided guidance.

People's medicines were ordered, stored administered and disposed of safely.

There were enough staff working to provide the support people needed. Recruitment procedures ensured only suitable staff worked at the home.

People were protected from the risks of harm, abuse or discrimination because staff had a good understanding of safeguarding procedures.

Is the service effective?

Good

The service was effective.

People were given choice and staff worked within the principles of the Mental Capacity Act 2005.

There was a training programme for staff and they received regular supervision.

People were supported to eat and drink a choice of food that met their individual needs and preferences.

People's health and well-being needs were met. They were supported to have access to healthcare services when they needed them.

Is the service caring?

Good

The service was caring.

People were supported by staff who knew them well and were kind and caring. They treated people with kindness, understanding and patience.

People were supported to make decisions and choices about what they did each day.

People's dignity and privacy was respected.

Is the service responsive?

Good

The service was responsive.

People received care that was person-centred and met their individual needs and choices.

There was an activity programme which people enjoyed participating in as they wished.

Complaints had been recorded, investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements had been made to people's records and the quality assurance system. However, further time was needed to ensure improvement and changes are embedded into every day practice.

The registered manager was well thought of and supportive to people and staff.

Systems were in place to gather feedback from people and staff and this was used to improve the service.

Rivendale Lodge EMI 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 8 and 9 October 2018 and the first day of the inspection was unannounced. This meant staff did not know we were coming. The inspection was carried out by one 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.

Due to technical problems, the provider was not able to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Before the inspection we reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included two staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regard to the upkeep of the premises.

We looked at four people's care plans and risk assessments along with other relevant documentation to

support our findings. This included 'pathway tracking' two people living at the home. This is when we check that the care detailed in individual plans matches the experience of the person receiving care. It is an important part of our inspection, as it allows us to capture information about a sample of people receiving care.

During the inspection, we met with all the people who lived at the home, and those who could share their views did. Some people were unable to speak with us verbally. Therefore, we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing people in areas throughout the home and were able to see the interaction between people and staff. We watched how people were being supported by staff in communal areas.

We spoke with nine staff members and the registered manager. We also spoke with five visitors, two visiting health and social care professionals. Following the inspection, we contacted two health and social care professionals who visit the service to ask for their feedback.

Good

Is the service safe?

Our findings

Through our observations we saw that people felt safe in the company of staff. They responded positively to staff presence and approached staff if they were concerned. Visitors told us their relatives were safe at the home. One visitor explained that their relative had a pressure mat near the bed and could call for assistance by stepping on to the mat. The visitor told us this made their relative feel safe. People were protected against the risk of abuse, harm and discrimination. Staff received safeguarding training, they understood their own responsibilities and could tell us what actions they would take if they believed someone was at risk. They told us how they would report their concerns to the registered manager or if appropriate, to external organisations. When safeguarding concerns were raised, the registered manager worked with relevant organisations to ensure appropriate outcomes were achieved. Information about safeguarding concerns and outcomes were shared with staff.

When any concerns were raised the registered manager ensured all staff were aware, as far as appropriate, what had happened and what steps to take to prevent a reoccurrence. Information was shared at shift handover and recorded in the communication book for staff to read. Following a recent concern, the registered manager had held a meeting, concerns were discussed and actions taken. This included staff not using their personal mobile phones whilst they were working.

People were supported to remain safe. Risks were well managed and helped people to remain safe without unnecessarily restricting their freedom or limiting their independence. Staff understood the risks associated with people's care and support. They told us how they ensured people who remained in bed had their positions changed regularly and how they supported people to remain mobile and safe. There were a range of risk assessments which provided further guidance. Risk assessments contained information about people's mobility, skin integrity, behaviours that may challenge and health related conditions such as diabetes. Where people were at risk of developing pressure wounds there was guidance about regular position changes and the use of pressure relieving mattresses. We observed this taking place throughout the inspection. Accidents and incidents had been recorded and included details of actions that had been taken. Individual analysis of incidents helped to identify if there were any themes or trends. Staff were aware of the importance of recording any incidents or accidents that occurred.

People received the support they needed in a safe and timely way because there were enough staff working each shift. Visitors told us there were enough staff working. One visitor said, "There's always staff around." The registered manager had identified that staffing numbers needed to increase and this had happened at the time of the inspection. This was based on the number of people living at the home and their individual needs. There were five staff working during the day. An activity co-ordinator started work at 12.30pm to help provide extra support for people with their lunchtime meals. From 8pm there were three staff and two staff overnight from 10pm. Either the registered manager or a member of laundry staff started work at 7am. This was to support people, who were up, to have a morning cup of tea. There was a cook and kitchen assistant each day. The kitchen assistant supported people with their breakfasts and hot and cold drinks throughout the day. There was domestic and laundry staff working each day. The deputy manager had allocated shifts when they did not provide care and were able to complete their management role. This meant, in addition

to providing care, people could see there were staff around if they needed them. This helped people to feel safe because there were familiar faces around.

People were protected, as far as possible, by a safe recruitment practice. Staff files included the appropriate information to ensure all staff were suitable to work in the care environment. This included disclosure and barring checks (DBS) and references. There was ongoing recruitment and staff did not start work until appropriate checks had been completed.

There were systems in place to ensure medicines were ordered, stored, administered and disposed of safely. Medicine administration records (MAR's) were completed and showed people had received their medicines as prescribed. Some people had been prescribed 'as required' (PRN) medicine. People only took this when they needed it, for example if they were in pain or anxious. Where PRN medicines had been prescribed there were individual protocols in place to ensure people received these appropriately and consistently. During the inspection people were given their PRN medicines when they needed them. Staff were clear that alternative approaches, including reassurance and comfort were provided before people were given PRN medicines for anxiety. The registered manager told us how they had consulted with a person's GP to ensure the PRN medicines they received were being given appropriately.

Where people expressed particular preferences about how they liked to take their medicines these were respected. One person liked to see the boxes their medicines came from and make choices about whether they took them or not. Staff went out of their way to support this person. They had been prescribed a medicine with a dose of 10mg. This had been increased to 20mg, therefore the box the tablet had been provided in had changed. This caused distress to the person. The registered manager discussed this with the pharmacist and the medicine was dispensed in 10mg tablets and the person was happy to take two of these which helped to ensure their health needs were met.

Only staff who had received medicine training and been assessed as competent were able to give medicines. They had a good understanding of people and the medicines people had been prescribed. Medicine audits were in place to help identify any shortfalls.

The home was clean and tidy. There were designated housekeeping staff who were responsible for the day to day cleaning of the home. There was an infection control policy and Protective Personal Equipment (PPE) such as aprons and gloves were available and used during the inspection. Hand-washing facilities were available throughout the home. The laundry had appropriate systems and equipment to clean soiled linen and clothing.

Environmental and equipment risks were identified and managed appropriately. The registered manager was aware of areas where improvements were needed and re-decoration at the home was ongoing. Maintenance staff were available when needed. Servicing contracts were in place, these included gas, electrical appliances and the stair-lift and moving and handling equipment. Where works had been identified through the servicing contracts work was on-going to address these.

Personal emergency evacuation plans (PEEPs) were in place to ensure staff and emergency services were aware of people's individual needs in the event of an emergency evacuation. Regular fire checks took place and this included fire alarm testing. The registered manager told us a recent fire risk assessment had identified some work was needed and this was being addressed.

Good

Is the service effective?

Our findings

At our inspection in August 2017 we found there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the provider needed to make improvements to ensure that where people did not have the capacity to consent, the registered person had acted in accordance with legal requirements. At this inspection we found improvements had been made and the provider was now meeting this regulation.

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. Mental capacity assessments were in place and identified where people lacked capacity. There was information about why and how decisions had been made in people's best interests. Where people were sharing a bedroom, there was information about why this was appropriate and discussions that had been held with family members. Throughout the inspection we saw staff asking people for their consent before they offered care and support. Staff had understood MCA, the importance of offering people choices and respecting those choices.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met. DoLS applications had been submitted for people who did not have capacity and were under constant supervision. Copies of the applications and authorisations were available to staff. Some people had lasting power of attorneys. There was information about what these covered and who could legally act on the person's behalf. The registered manager had also developed a document that looked at the way DoLS affected people's lives and what staff could do to minimise restrictions. This included ensuring people were given choices and supported to go out if they wished.

People's needs were assessed and care and support was delivered in line with current legislation and evidence-based guidance. For example, people's skin integrity and their risk of developing pressure wounds had been assessed using a Waterlow risk assessment. These assessments were used to identify which people were at risk of developing pressure wounds and action taken included appropriate equipment to relieve pressure to their skin, such as specialist cushions and air mattresses. Staff also received advice and guidance from visiting healthcare professionals which helped ensure care and support was up to date and appropriate.

People received support from staff who received regular training and supervision to help ensure they had the knowledge and skills to support people effectively. When staff started work at the home they completed an induction. This included an introduction to the home, the general day to day running, they read the policies and were introduced to people. They completed some training and spent time shadowing regular

staff, until they were competent and confident to provide care unsupervised. Induction checklists were in place and these were signed when completed. The registered manager told us staff who were new to care would complete the care certificate. This is a set of 15 standards that health and social care workers follow. It helps to ensure staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

There was a training program and this included moving and handling, infection control, safeguarding and dementia. Training was provided face to face at the home. Staff told us this was beneficial as it gave them the opportunity to learn the theory, ask any questions and relate what they had learnt to people who lived at the home. This was of particular benefit to staff whose first language was not English as it gave them an opportunity to ensure they had understood the training, through further discussion. The training programme was ongoing and we saw further training in relation to food hygiene, falls awareness and medicines had been booked. Staff were encouraged and supported to continue their learning and development through further training. This included Diploma in Health and Social Care in levels 2, 3 and 5.

There were no formal competency assessments of staff following training. The registered manager told us informal competency assessment took place through day to day observation of staff working. Any concerns would be identified and addressed. We saw in minutes of staff meetings staff had been reminded of their responsibilities and how to use correct moving and handling procedures. We recommend the provider consider a formal competency process to include documentary evidence to support staff's learning.

There was a supervision program and staff received regular supervision. This helped identify any areas where further support or development was required. We saw staff, who required it, had received extra supervision and support. Staff told us they felt supported and could discuss any concerns with the registered manager. Supervision responsibilities had been delegated to the deputy manager and a senior care worker. Staff were given the opportunity to indicate on their supervision form if they would like to have a discussion with the registered manager.

People were supported to eat a wide range of food and drink to meet their individual nutritional needs. People were provided with a choice of food and drink each day. These choices reflected people's cultural and religious preferences and also their individual likes and dislikes. Where people were less able to make choices, they were supported by staff who understood them well, through discussions and pictures. People were living with dementia and staff understood how this may affect the choices people made. A staff member explained how one person, who had previously not liked sugar in their tea, would on occasions ask for sugar and this was provided. If people changed their minds about their meal choices or did not like what was on offer then alternatives were provided.

As far as possible, mealtimes were relaxed and sociable occasions. People were supported to have their meals where they wished. Most people ate in the dining room, some remained in the lounge area and others sat in the conservatory. One person chose to sit outside as the weather was warm. Mealtimes were planned and paced to suit people's needs. Staff had identified that some people would leave the table as soon as their main course was finished. Therefore, staff were observant and ensured people received their pudding once they had finished their main course. This helped to ensure people had enough to eat. Other people ate slower and were supported to eat at their own pace. People received the support they needed, this included prompting and encouraging. Staff described how some people needed guidance to start eating but would then be able to manage with minimal support. People were supported to maintain their independence with plate guards and some people preferred their meals served in bowls. This enabled them to manage their meals without support. Where people remained in bed they received the appropriate support from staff to eat and drink enough throughout the day.

Some people had complex needs in relation to eating and drinking and needed specialist diets, for example pureed and fortified meals. These were provided appropriately and staff understood the reason for these diets. When people were at risk of malnutrition then their food was fortified to add extra calories. The cook and staff had a good understanding of people's dietary needs and how to support them.

People were supported to maintain good health. They received on-going healthcare support and could see their GP when they wished and when there was a change in their health. During the inspection one person developed a health concern and staff supported the person to attend the GP surgery for advice and guidance. Where possible staff supported people to attend appointments rather than asking for GP visits. This meant people had the opportunity to discuss health issues, with support from staff, in a more private setting. Where people were living with health-related conditions staff supported them to attend regular health checks and appointments.

People's needs were met through the design and adaptation of the home. There was a stair lift and staff supported people to use this when they needed. There were signposts, which included the written word and matching picture, throughout the home. These helped people find their way around. There were adapted bathrooms and toilets to support people. People could move freely around the home as they wished. There was level access, through the conservatory to a rear decked area which people could access independently. The conservatory door was unlocked throughout the day. This enabled people to go outside when they wished. There was a larger decked area and garden which people could access with the support of staff. The garden was well-maintained and included a variety of garden ornaments as well as plants. There were raised planters which contained sensory herbs. Staff had supported people to plant these and assist with the gardening throughout the summer. The registered manager told us the design to the home was constantly reviewed to ensure it met people's needs.

Good

Is the service caring?

Our findings

Staff treated people with kindness, compassion and patience. A visitor told us, "They give wonderful care here, the staff are very nice." The visitor said their relative looked well and that staff knew them well. They added, "They speak nicely to (name), they show respect and kindness." Another visitor told us staff had "nurtured" their relative. Staff supported people in the way that people wanted. One staff member explained how they worked. They told us they worked at each person's pace. If people took longer to get up or eat their meal then that was fine. The staff member emphasised Rivendale Lodge was people's home and the care provided was for the benefit of people not staff. They told us although tasks needed to be completed these were not time driven but based on people's needs and choices each day. This helped to promote a relaxed and homely atmosphere at the home.

People responded positively to staff presence. Staff greeted people warmly when they came on shift or when people got up. People demonstrated they were pleased to see staff through smiles, greetings and hugs. As people were living with dementia these greetings happened frequently throughout the day. Staff always responded and this included appropriate hugs and other gestures of affection, greetings and smiles. Staff spoke about people with real affection and understanding. They knew people really well and had developed positive relationships with them and their families.

People were supported and encouraged to maintain contact with relatives and friends. Visitors were always made welcome at the home. Visitors told us they were able to visit whenever they wished and were always greeted by familiar staff who they knew. One person was expecting a telephone call from a relative they had not seen for a while and staff were supporting the person to speak with them privately.

People were supported to make their own choices and decisions and maintain their independence. People could get up and go to bed when they liked and were supported to make decisions about what they did each day. Some people enjoyed walking around the home and were able to do this freely. If people wished to remain in their rooms then this was respected. Where people were less able to make their own decisions, staff promoted their independence through prompting, encouraging and supporting them. For example, at mealtimes and when walking.

Staff responded appropriately to people when they were anxious or distressed. One person was distressed when moving into the home. All staff spoke to the person, they introduced themselves and welcomed them to the home. Staff sat with the person and held their hand. One staff member offered the person a cup of tea which they accepted. The person then became distressed again because they did not like the cup, the staff member replaced it with a cup the person preferred. The person then became distressed because they wanted a tray to put the cup on. Again, this was provided by the staff member. This whole interaction was done with kindness and patience. The staff member recognised the person was upset and provided them with comfort and reassurance. Staff were attentive to details in people's behaviour and used this information to support them. The registered manager had identified that if she wore brightly coloured clothes people did not recognise them. Therefore, they only wore black, white or grey to work.

People's dignity and privacy was maintained. People were supported to maintain their own personal hygiene and appearances. They were able to wear clothes that were well laundered and of their own choice. One person was wearing jewellery and this was clearly important to them. Staff complimented people on their appearance and what they were wearing. Staff were observant to situations which may impact on people's dignity. They told us about one person who was reluctant to change their clothes. They were aware the person liked to look clean and tidy. However, reminding the person to change their clothes caused them to be upset. They told us this was managed carefully and in time the person would agree. People's bedrooms were personalised with their possessions such as personal photographs and mementos and arranged in a way that suited each person.

Staff had a good understanding of dignity, equality and diversity. They were aware of the need to treat people equally irrespective of age, disability, sex or race. People were supported to maintain their spiritual and religious choices. There was information in their care plans and staff were aware of people's beliefs. One person was reading religious books and staff told us this person was comforted when they could read their daily prayer book. The person asked the staff what the date was and then referred to that date in the daily prayer book.

Staff respected people's individual knowledge and skills. Two staff, whose first language was not English, told us how some people corrected their language when they were speaking. Both staff appreciated this and one told us they would on occasions gain advice from people. The staff member told us this helped the person retain their own knowledge and skills and helped the person feel worthwhile.

Good

Is the service responsive?

Our findings

People received care that was person-centred and met their individual needs and choices. Staff knew people well, they could tell us about people's individual care and support needs and preferences. Staff could talk to us about people's personal histories and their families. Before people moved into the home the registered manager met with the person, and where appropriate their relatives to complete an assessment of their needs. This was to ensure the person's needs, choices and preferences could be met at the home. It also helped to confirm the staff had the knowledge and skills to look after them appropriately. Information from the assessment was then used to develop care plans and risk assessments to provide guidance to staff. Care plans were regularly reviewed to ensure they reflected people's current needs. Where appropriate care plan reviews took place with people and their relatives. There was information to show how often people's relatives wished to be involved in the care plan reviews. For example, some wished to be involved every six months and others when changes were taking place. Relatives told us, even if they weren't involved in the reviews, they were always updated about any changes or concerns with their loved one's care.

Care plans were person-centred and included information about people's mobility, their skin integrity and nutrition. Some people displayed behaviours that may challenge and care plans provided guidance about how to provide appropriate support to people. Where people needed their positions changed regularly staff ensured this was done and understood the importance of this to reduce the risk of pressure damage. Some people required support to maintain their continence and there was an emphasis on finding a plan or routine which worked for each person. For example, staff were supporting one person to use the facilities at regular times. Records were kept to help identify if this was a good routine for the person or if changes were needed. Care plans contained information about people's personal histories. Some of these had been completed by people with support from their families. Where this was not possible they had been completed by staff and identified that this is what staff knew about the person since they moved into the home.

There were a range of activities taking place each day and people were supported to take part and do what they enjoyed. Some of these were group activities and staff supported other people to engage in individual activities. We observed staff providing the newspaper for some people each morning. A staff member discussed with another person what they would like to watch on the television and supported them to find a programme they really enjoyed. The staff member offered a number of choices and the person said what they would like to watch. The staff member then made another suggestion and the person was delighted with the new suggestion and clearly enjoyed watching the programme. On other occasions there was music playing which was appropriate for people. Staff understood the importance of ensuring people remained stimulated to help improve their quality of life. Therefore, they spent time sitting and chatting with people and where possible using the time to help people reminisce. Staff understood they needed to adapt their approach with people as their dementia changed. One staff member told us how they prompted one person to talk about their time overseas. They used their knowledge of what the person had shared previously, to stimulate their memories.

Staff told us there was a weekly activity programme. However, this was not strictly followed and activities

were based on what people enjoyed doing. They told us, at the moment, people enjoyed playing with a large beach ball. The staff member told us, and we later saw, that this stimulated people's interests and they enjoyed participating. We saw people happily kicking and hitting the ball to each other and having fun. The staff member told us they were continually looking at different activities for people and further training had been booked to develop staff knowledge and skills. There were pictures displayed throughout the home which showed people engaging and enjoying a range of activities throughout the year.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Communication care plans contained information to guide staff. This included whether people wore glasses or hearing aids. Staff communicated appropriately with each person and understood the importance of communicating in a way that met people's individual needs. This included using simple words and sentences.

There was a complaint's policy in place and records showed complaints raised were responded to and addressed appropriately. At the time of the inspection the provider was investigating one complaint that had been raised. People's concerns were addressed as they arose. This prevented them becoming formal complaints. Visitors told us they had not had any complaints but would talk to staff if they did. One visitor said, "I have no worries, but if I did have concerns, I would approach the manager." Where appropriate, any complaints received were discussed with staff. This helped to ensure, as far as possible, that lessons had been learnt and actions taken to prevent a reoccurrence.

As far as possible, people were supported to remain at the home until the end of their lives. Staff were aware of the support people needed to keep them comfortable in their last days. Care plans contained some information about people's end of life wishes. These had been discussed with people and their families. These wishes were respected. Some people chose not to discuss their end of life wishes and this was also respected. Staff liaised with healthcare professionals to ensure the appropriate support was in place. This included anticipatory or 'just in case' medicines which had been prescribed and were stored at the service should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in August 2016 we found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our inspection in August 2017 we found the provider was still not meeting the requirements of Regulation 17. This was because people's records did not reflect their assessed needs or the level of support they required and received. This had not been identified through the quality assurance system. We followed our enforcement policy and told the provider this must be addressed. We also met with the provider and received assurances from them that improvements would be made.

At this inspection we found improvements had been made and the provider was meeting the regulations. However, further work and time was needed to ensure on-going improvement and changes already made are fully embedded into every day practice.

Care plans were much improved. They were person-centred and contained information staff needed to provide the care and support people needed. The provider had introduced a computerised care planning system. This meant all care plans needed to be transferred to the computer and would have to be written in a different format. These were in the process of being completed but the registered manager had identified this would take time to do. Paper copies of people's care plans remained until this could take place. There was an overview of each person's care needs on the computer which gave 'at a glance' information about their support needs and was easily accessible to staff. The registered manager had completed one full care plan on the computer. This had been printed out and shared with staff to help identify where improvements were needed to ensure care plans, in the new format, remained person-centred and detailed.

Care staff completed their daily notes on a hand-held electronic device, like a mobile phone. These were a tick box system with the opportunity for staff to add further comments and provide more detail when needed. Staff were able to access people's computerised care plans on this device. Again, staff needed to develop confidence and skills to use these devices to their fullest. Some staff were more confident and were supporting their colleagues.

Improvements had been made to the quality assurance system. Previously, audits of people's care plans had not identified areas that needed to be developed. The provider had engaged the services of an external consultant to provide support and promote improvements. Areas identified had been addressed or were in the process of being addressed.

Mental capacity assessments and best interest information was now included in people's care plans. However, this did not always include the detailed information about how best interest decisions were made and how people's opinions were sought. This had been identified through the audit process and the registered manager had sought support through the local authority Market Support team. Work had started to improve this using the computerised mental capacity assessment. The registered manager was aware they needed to include more detail, and also identified their own need for further support. We had received assurances from the Market Support team that this guidance would be provided.

There were other checks and audits in place to help identify areas for improvement and they had been identified and addressed. For example, not enough medicine had been sent and contact had been made with the pharmacy. There was analysis of accidents and incidents and this had been completed on the computer. The registered manager told us although this gave an overview it did not provide all the information needed therefore they would be looking at additional ways of recording this information. The registered manager had a good oversight of other improvements that were needed, for example, there were areas of the computerised system they needed further support with or that appeared to need developing such as where to record people's life histories.

There was a clear management structure. The registered manager was supported by the provider, a deputy manager and senior carers. There was an on-call system so that staff knew who to contact in case of emergency. The registered manager was highly thought of by people, visitors and staff. She was a visible presence at the home, they regularly provided support to people and to staff. Throughout the inspection we saw people approaching her with smiles and hugs. They clearly knew her well and enjoyed being in her company. Visitors told us she was approachable and they could talk to her at any time. Staff felt supported by her. One staff member said, "If I have any concerns I speak to the registered manager, two minutes later I don't have any concerns." Another staff member told us any concerns discussed with the registered manager would be addressed appropriately and would remain confidential. The registered manager's office was by the lounge, the door was always open and she told us this enabled her to be aware of what was happening at the home. She told us she led by example and would not expect staff to do anything she wouldn't.

Staff were updated about changes in people's care and support needs at a handover each morning and between shifts. This gave staff the opportunity to discuss matters relating to individuals and their care and support needs. There were regular staff meetings and these were used to identify any concerns, inform staff about changes and planned improvements. These meetings allowed for discussion and communication with staff. Staff meeting minutes included reminders to staff about completing daily records and individual aspects of people's care.

The provider asked for feedback from people and relatives. This was through satisfaction surveys and regular contact with people and their relatives. A recent feedback survey had been completed by people's relatives but this had not yet been analysed. All feedback forms contained positive comments, complimenting the registered manager and staff for the care they provided.

The registered manager was an active member of the local care homes association. They engaged with local stakeholders and health and social care professionals to ensure they were up to date with changes in legislation and best practice.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. There was a procedure in place to respond appropriately to notifiable safety incidents that may occur in the service.