Avon Lodge UK Limited

Avon Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 9 and 10 May 2018 and was unannounced. Avon Lodge 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 home provides personal care and support for up to 36 people, some of whom have dementia. At the time of the inspection there were 31 people living at Avon Lodge. It is a large two storey building and people's bedrooms are on both first and second floors. There is a large communal lounge / dining room as well as a smaller communal lounge. The home has a large well-kept garden with outdoor seating areas.

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

The home had been rated as 'inadequate' in September 2015 and again in April 2016. At an inspection in October 2016 we rated the service 'requires improvement' overall but 'inadequate' in well-led'. At our last inspection on 21 and 22 March 2017 we found that there had been significant improvements and found no breaches of regulations. However, we needed to be assured that improvements would be embedded and sustained and the home was again rated as 'requires improvement'.

At this inspection we found that the improvements had been embedded, further improvements had been made and there were no breaches of regulation. The home is now rated 'good'.

People told us that they felt safe living at Avon Lodge. Staff had received safeguarding training and understood how to recognise and report abuse.

We observed warm and friendly interactions between staff and people throughout the inspection. Staff knew people well.

People's risks were well documented and care was provided to people in the least restrictive way whilst being aware of people's personal risks. Risks were regularly reviewed.

The home assessed and monitored people's risk of malnutrition and pressure ulcers and made referrals to specialist health professionals when necessary. Fluid charts were not always completed properly. However, this was addressed at the time of the inspection.

Medicines were well managed and people received their medicines safely and on time. People received 'as

needed' medicines when necessary. However, there were no protocols for when to administer these medicines. Following the inspection, the registered manager addressed this issue.

Staff were aware of infection control and how to keep people safe from the spread of infection. The home provided gloves and aprons for staff when delivering personal care.

There were regular maintenance checks and staff were aware of how to report maintenance issues.

The home was clean and smelled fresh throughout the inspection.

Staff received regular supervision, appraisal and training to support them in their role.

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 support this practice.

There were individualised care plans written from the point of view of the people that were supported. Care plans were detailed and provided enough information for staff to support people. Care plans were regularly reviewed and updated immediately if changes occurred.

The home recognised that stimulation and enjoyment were essential to people's wellbeing. There was a wide variety of activities that people could choose to take part in. People were supported and encouraged to engage in activities.

People received good quality food and there were always drinks available to ensure hydration. Where people required specialist diets, we saw that this was being provided.

People and relatives were encouraged to help plan end of life care in a tailored way. Staff were compassionate regarding caring for people at the end of their lives.

There was a complaints process in place and people and relatives knew how to make a complaint. Complaints were investigated and followed up.

Visitors told us that they felt welcome within the home and able to visit whenever they wanted.

Audits were carried out across the service on a regular basis on medicines management, health and safety and the quality of care. Surveys were completed with people who use the service and their relatives. Where issues or concerns were identified, the manager used this as an opportunity for change to improve care for people.

People and relatives felt that there had been a great improvement in the service. The manager and management team were accessible to people and relatives were confident in the care that was being provided.

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 understood safeguarding and how to report any concerns.

There were sufficient staff to ensure people's needs were met.

Risks for people who used the service were identified and risk assessments were in place to ensure known risks were mitigated against.

People's risks of pressure ulcers and malnutrition were regularly assessed and reviewed.

People were supported to have their medicines safely. Staff were knowledgeable about the medicines they were giving.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Staff received regular supervision. Appraisals were in the process of being completed. People were supported by staff who regularly reviewed their working practices.

Peoples healthcare needs were monitored and referrals to specialists made when necessary

People were supported to have enough to eat and drink so that their dietary needs were met. Where people had specialist dietary needs, these were understood and catered for.

Is the service caring?

Good

The service was caring. People were supported and staff understood individual's needs.

We observed that people were treated with respect and staff maintained privacy and dignity. Staff treated people kindly and

were patient and kind in their interactions.

Staff understood how to work with people that had behaviour that challenged.

People were encouraged to have input into their care.

Is the service responsive?

Good

The service was responsive. People's care was person centred and planned in collaboration with them and their relatives.

Staff were knowledgeable about people's individual support needs, their interests and preferences.

The home provided a lot of activities and people were encouraged to take part.

People knew how to make a complaint. There was an appropriate complaints procedure in place. The home responded appropriately to any complaints.

End of life care was compassionate and planned according to people's and relatives' wishes.

Is the service well-led?

Good

The service was well-led. There was good staff morale and guidance from management.

The home had a positive open culture that encouraged learning.

Systems were in place to ensure the quality of the service people received was regularly assessed and monitored.

There were systems in place to ensure learning and sharing best practice which all staff were involved in.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 10 May 2018. The inspection was carried out by two adult social care inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One expert by experience attended the inspection and spoke with people to gain their views and opinions of the home. The second expert by experience supported this inspection by carrying out telephone calls to people's relatives following the inspection.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We also looked at safeguarding notifications that the provider had sent to us. Providers are required by law to inform CQC of any safeguarding issues within their service.

We used information the provider sent us on 6 April 2018 in the Provider Information Return. 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.

During the inspection we spoke with nine staff including the registered manager, the nominated individual, the deputy manager, six care staff, and the activities coordinator. We also spoke with 23 people that were living at the home and two relatives that were visiting at the time as well as a visiting healthcare professional. We looked at seven people's care records and risk assessments, 10 people's medicines records, three people's fluid charts, five staff files, and other paperwork related to the management of the service including staff training, quality assurance and rota systems. Following the inspection, we spoke with eight people's relatives.

Good

Is the service safe?

Our findings

We asked people if they felt safe living at Avon Lodge. One person told us, "Yes I am safe, safe like a golden girl. Everybody looks after everyone, they are polite and kind" and, "Of course I'm safe. The staff know me." Relatives were positive about their loved ones' safety and comments included, "The home is very safe. Staff never ignore incidents and take the person to one side", "The doors are kept locked, so residents can't just walk out, as you saw I was waiting outside for a while to be let in. I trust them [staff]. I trust the people here" and "I can't fault them. I have a background in home care and support so I am very aware of issues around safety."

Staff were able to explain how they would keep people safe and understood how to report it if they thought people were at risk of harm. There were notices in the staff room telling them who to contact if they needed to report abuse. People told us and we saw, that safeguarding was discussed in residents' meetings and both people and staff were encouraged to report any concerns if they needed to. The service's safeguarding policy was available and accessible to staff. Staff training records showed that staff had completed training in safeguarding. One staff member told us, "I would report straightaway. To protect residents from abuse."

People's individual risks were well documented within their care plans. Each risk had been clearly recorded and detailed guidance provided for staff to ensure that they understood how to minimise the person's known risk. This included risks for falls, diet, behaviour that challenged the service, bed rails, pressure ulcers and skin integrity. Each care plan had a safety page that provided an overview of each person's health needs and risks and explained 'What you must do to keep me safe'. For example, one care plan explained a person had a specific health condition and the risk could be reduced by a specific diet. We saw that the person was receiving this specific diet. Care plans and risk assessments were reviewed yearly or updated when there was a change in people's risk factors.

The home used the Malnutrition Universal Screening Tool (MUST) to assess people's risk of malnutrition. Where appropriate we saw that people were referred to speech and language therapists (SALT) for assessment. MUST assessments were reviewed monthly. For example, for one person that had been noted as being at medium risk, we saw that they had been seen by a SALT and the review stated, 'to continue on fortified meal'. The person's care plan documented how their meals should be fortified. This information was also clearly displayed in the kitchen and the chef was able to explain how they prepared the person's meals.

People's potential for developing pressure ulcers was regularly assessed by using the Waterlow scale. The Waterlow scale is a specific way of estimating the risk to an individual of developing a pressure ulcer. Where people were at risk of developing a pressure ulcer, we saw that pressure relieving equipment such as mattresses and cushions were in place. For one person, we saw that they had been referred to the district nurse and were being seen on a regular basis. A relative told us, "[Person] came to the home from hospital with a pressure sore. The home have been very good at providing the care required to get [person] physically better."

Falls were well managed within the home. Falls that people experienced were followed up and analysed for any patterns and ways to minimise the risk for that person and a monthly overview completed. For example, an analysis of falls in January 2018 found that falls tended to happen between 9pm and midnight. As a result of this, increased monitoring for people at risk of falls was put in place and the number of falls had decreased. Where people had two falls or more within a month, the person had been referred to the falls clinic held at the home by the Care Homes Assessment Team (CHAT). This is an external team of healthcare professionals that support care homes in the Enfield area.

Where necessary staff maintained fluid charts that documented the amount of fluid the person had every 24 hours. The amount of fluid that a person required was not documented and amounts given daily were not totalled. This meant that staff were unable to ensure that a person had received the correct amount of fluid or take action if they had not had enough. For one person on fluid restrictions due to a medical condition, this information was reflected in the person's care plans and risk assessments but not on their fluid chart. We discussed this with the deputy manager who amended the form to include this information and advised they would review the information with the relevant health professional. Other fluid charts were immediately updated to reflect how much fluid a person should have. Staff that we spoke with were aware of who needed a fluid chart and why.

Medicines were overall well-managed within the home and the home had a clear medicines administration policy which staff had access to. People's medicines were recorded on medicines administration record (MAR) sheets and used the blister pack system provided by the local pharmacy. A blister pack provides people's medication in a pre-packed plastic pod for each time medicine is required. We saw that people's medicines were given on time and there were no omissions in recording of administration in the month prior to the inspection.

One person's medicines record noted that they were receiving their medicines covertly. Covert administration of medicines is used when a person actively refuses their medicines and is judged to not have the capacity to understand the consequences of refusal. The medicines are often concealed in food or drinks, and requires authorisation of the GP and dispensing pharmacist. Where the person's medicine was administered covertly it had been clearly documented how the medicine should be given and a best interests meeting had been documented and the family and relevant healthcare professionals involved.

There were appropriate systems in place for managing controlled drugs (CD). Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations. CDs were audited daily and we found that audits accurately reflected the usage of CDs within the home. There were suitable systems in place for the disposal of medicines.

Staff had received medicines training and we saw that all staff that administered medicines underwent yearly competency assessments. There were also monthly competency checks. This ensured that staff understood how to safely administer the medicines and were regularly monitored. People's care plans also documented what medicines people had been prescribed and how staff should administer their medicines.

There was inconsistent guidance in place for people receiving 'as needed' (PRN) medicines. 'As needed' medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they become anxious or are in pain. We found that 23 people did not have PRN protocols in place. This included for medicines such as painkillers, inhalers and constipation relief. PRN protocols provide staff with guidance on what circumstances to offer and administer the medicine. A medicines audit completed by the home dated 19 February 2018 had identified that, 'all residents do not

have PRN protocols'. However, at the time of the inspection the lack of PRN protocols had not been addressed. Staff that we spoke with were aware of when to offer PRN medicines and MARs showed that people were receiving PRN medicines when necessary. We raised the lack of written PRN protocols with the registered manager who said that this had been identified and the protocols were being implemented. This was also confirmed by a senior carer who had responsibility for medicines. Following the inspection, the registered manager sent us a completed PRN protocol which contained all relevant information.

A healthcare professional told us and we saw that people received regular medicines reviews. The healthcare professional told us, "With [the GP] we are having multidisciplinary meetings every two weeks or so where we go through five people at a time. We review them, look at their medicines and any healthcare referrals. It's a holistic review."

The home ensured that staff understood infection control and how to protect people from infection. Staff had been trained in infection control and the service ensured adequate supplies of personal protective equipment (PPE) such as gloves, aprons and shoe covers. Staff told us that they always had access to PPE. We observed staff using PPE throughout the inspection. We saw that staff washed their hands before serving food and that food taken to people who wished to eat in their bedrooms, was covered during transportation.

The service followed safe recruitment practices. Staff files showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role. However, some staff criminal records checks were several years old, with one from 2004, and the home was not renewing criminal records checks every three years in line with best practice. We raised this with the manager who said that this would be reviewed.

There were detailed plans and risk assessments for each individual in case of emergencies within the home. Each person had a personalised emergency evacuation plan (PEEP) which the staff were aware of, including manual handling directions and how many staff would be needed to safely evacuate that person. PEEPs were reviewed monthly and updated if there were any changes. We saw that for one person the home was completing a re-assessment of their PEEP as the person had had a significant deterioration as a result of their dementia which meant their needs had changed in case of an emergency. The service regularly tested the fire alarm systems and held fire drills.

During our inspection, the home also had an unannounced inspection form the London Fire Brigade. We received feedback that the fire brigade would be serving an enforcement notice regarding issues found at the inspection. The home was given a specific timeframe in which to complete these actions. On the second day of the inspection we saw that the nominated individual and the registered manager had begun to address the concerns.

The home had a call bell system where people were able to alert staff if they needed help. Call bells were located in people's bedrooms as well as bathrooms and toilets. We rang a call bell in a person's upstairs bedroom and staff attended within one minute. People told us that staff answered call bells quickly.

There were records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. There had been six accidents or incidents documented since January 2018. Incidents were recorded in detail and any action taken at the time of the incident had been recorded. Any accidents or incidents were discussed at staff meeting and any learning shared. For example, how to work effectively with a person that had become aggressive during a particular situation.

The home had up to date maintenance checks for gas, electrical installation, lift maintenance, hoists and fire equipment. Staff understood how to report any maintenance issues regarding the building.

Good

Is the service effective?

Our findings

People's needs and choices were assessed and met within the home This helped staff to understand people's individual care needs and supported them to provide effective care. Relatives felt that staff were well trained and provided good care. Relatives commented, "I think staff are well trained, they know what they are doing" and "Staff are very good at knowing what to do. Most of them seem to have lots of experience."

Staff undertook an induction programme when they began working at the home. The induction programme included the opportunity to shadow experienced staff, tour the building and understand health and safety procedures, read individual care plans and introduce themselves to the people living at the home. The induction schedule listed training to be completed such as, Safeguarding, First Aid, Health and Safety, Food and Hygiene, Manual Handling, Medicines, Dementia, Infection Control and MCA and DoLS. However, whilst staff told us that they received a comprehensive induction the documentation did not reflect this. There was a tick box sheet that was completed but there was no detail on the induction, how long it was or information on staff progress. We raised this with the registered manager who told us that the induction process was being reviewed. One staff member said, "A lot of shadowing, I was given the layout of the building, so I was aware of fire exits and when alarms go." Another said "They [management] show me [people's] rooms, the name of the [person] and where the Care Plan is."

Staff received regular training. One staff member told us that, "There is always some sort of training." On the first day of the inspection we saw that staff were attending a fire safety training day. There was an overview training record that documented when staff had completed training and when it needed to be reviewed.

Staff received regular supervision. One staff member said, "They do happen. If I have any problems or concerns or need help or if I am not happy with something, it gets fixed." Another said "They are good. During the supervision we can talk about how we feel and what problems we have and what can be improved. We look at daily challenges." Staff told us that they felt supported by the management of the home and were able to seek support whenever they needed to.

Staff had not received an annual appraisal since 2016. The registered manager told us that this had been recognised and there was a schedule in place to address this. Following the inspection, the registered manager sent us 11 completed staff appraisals. The appraisals were tailored for each staff member and included; training needs, an assessment of the previous year and an action plan to promote staff development. Staff were able to have input into the appraisal and their opinions were documented.

Before moving into the home an assessment was completed which looked at the person's care and emotional needs and how these would be met. Where appropriate, families were involved in assessments. Healthcare professionals' guidance and recommendations were also well documented and we saw that information from these assessments had been used to help create people's care plans, for example, information around moving and handling and specialist diets.

People were given a choice of what they would like to eat each day. The chef and staff checked each morning that people were happy with their choice of food and offered alternatives if people changed their minds. The menu was varied and catered for all people's needs, including cultural and dietary. People told us, "The food is superb" and another person was observed putting their thumbs up and smiled when they ate. We saw that people had access to drinks throughout the day and staff were seen to offer hot and cold drinks. People also had access cold drinks from a trolley located in the lounge and were encouraged to help themselves if they were able to. A relative told us, "There are plenty of drinks available they can be poured by residents."

A person told us, "Everything is good [with the food], they give me enough food, they feed you very well". We observed a staff member offering the same person some biscuits as a snack. Following being given the biscuits and tea, the person commented, "See they know what I want, they know what biscuits I like". Snacks were available throughout the day if people required them.

Where people required a specialist diet such as diabetic or pureed food, we saw that this was provided. Pureed food was well presented and each food item was placed separately on the plate to ensure that food looked appetising. We tasted the pureed food with the nominated individual and found that food was flavoursome and of a good consistency. Care plans documented people's dietary requirements and any specific dietary information was also located on a wall in the kitchen. The chef was aware of each person's individual requirements and was able to describe how he prepared specific diets.

Where people were on dietary restrictions this information was reflected in individual care plans and risk assessments and staff were aware of this. One staff member said, "One person has to control his weight so we reduce the portion with not too much sugar and not a lot of carbs, mainly veg and fish or meat." Another said, "Some of them are diabetic, so for example when we make tea we put sweetener not sugar, and some of them are on pureed food as they have problems to swallow." This meant that people were eating a healthy, balanced diet tailored to their needs.

Staff told us people could make choices for themselves about their daily lives and staff encouraged people to remain as independent and healthy as possible. One staff member said, "[Person] had a fall and went to hospital. When he came back he had to use a Zimmer Frame and he was scared, but now he walks by himself and goes to the toilet himself. Sometimes it is easier for us to use the wheelchair but it is more important we don't to help him." One person said, "I go for a walk every day. Walking helps with the pain." Another person was observed playing catch, the family member said, "This is good for their hands."

Hospital passports were also in place which provided important information about the person in the event of the person being admitted to hospital. For example, they included information about people's medical history, medicines they were taking and how best to communicate with them. One hospital passport explained that one person, when disorientated, will speak in their first language and could become frustrated if they were unable to communicate what they wanted.

Records showed that people had routine access to health care professionals, including GPs, dentists and chiropodists. Care plans were updated when people's needs had changed following healthcare appointments.

The service had a large garden, conservatory room, quiet lounge and a main lounge giving people and their visitors choice on where they would like to spend their time. One person had a visitor and they were sat in the conservatory together, the visitor said, "It is nice to visit and have some privacy." Another said the home was "beautiful" and "clean".

The premises had been decorated with simple wall and floor colours and co-ordinated furniture. The design of the communal areas had been well considered to create a positive atmosphere, for example the main dining room had chandeliers that provided good lighting and a focal point for people. The service was in the process of having each person's bedroom door painted to a colour of their choice. This was being done to help people identify their bedrooms. One staff member said, "This helps them feel at home." There were adapted bathrooms where people with mobility difficulties were able to receive personal care. Signs around the home were in large print so that people would be able to read them. A relative said, "The signage has vastly improved."

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 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 were well documented within the home. Where people required a DoLS, these had been applied for and there were records in place for when DoLS needed to be reviewed. Information on DoLS had been carried through into people's care plans and included information about what people were able to make decisions about and what they were unable to. There was guidance for staff on how to support people with decision making. This meant that people were being supported around their mental capacity in the least restrictive way.

Staff understood what the Mental Capacity Act was and how it impacted on the care that people received. One staff member said, "This [the MCA] is for people who no longer have the full capacity to make decisions about their care or daily activities so a DoLS is put in place to secure their safety and dignity." Another said, "People can make their own decision and if they can't you act in their best interest."

Each person had a pre-admission assessment that evidenced consent to care and treatment within the home and staff demonstrated an understanding of consent. One staff member said, "I cannot force people to do stuff but they should have a choice and I try to explain everything before I do it."

People's care records showed that people had access to various health care services. This included dentists, opticians and chiropodists. Where any advice had been given, people's care plans had been updated to reflect this. The home worked with the CHAT who visited every one or two weeks. CHAT supported the home with community psychiatrist nurses, continence nurses, palliative care, tissue viability nurses and other medical support. Relatives told us that the home always contacted them if there was a change in a person's health or they needed to be taken to hospital.

Good

Is the service caring?

Our findings

We asked people and relatives if they felt the staff were kind and caring. People told us, "Staff are more than just good they are wonderful and deserve lots of kisses", "I am enjoying it [Avon Lodge], it's the best home. People are generous, and kind and I love them" and "They are very kind, all of them. They look after me but I like my [particular staff member] she is the boss". Relatives comments included, "I have nothing but good to say about this place", "I think they are caring and kind, I have never seen anyone ill-treat anyone. [Relative] can be difficult, but they are good with him" and '[Staff are] very polite and responsive. [Relative] appreciates them and kisses the carers. [Staff] make you feel that you can talk to them." A healthcare professional commented, "Yes, they [staff] are caring. It's a team."

Throughout the inspection we observed warm and friendly interactions between people and staff and we saw staff talking and laughing with people. We observed one person who was very talkative and the person appeared to have a good relationship with staff. Staff would all would stop and have a conversation with the person.

Where people became distressed we saw that staff responded appropriately and spent time with the person. For example, one person became weepy and a staff member sat with her gently stroking her hand and offering support until the person felt better.

Where people showed behaviour that challenged the service this was responded to in an appropriate manner. For example, we observed two people in the lounge area at one table who had a verbal altercation. Staff were quick to give support and calm the situation, and one person was asked to move to sit at another table, which they willingly did. A member of staff sat and spoke to the people for a short while until they were both calmer. Relatives told us that they felt the home dealt well with behaviour that challenged. Comments included, "[Person] has always been difficult with their behaviour but, staff all handle him really well. Advice has been given on how to deal with them", [Relative's] behaviour can be inappropriate but staff handle the behaviour very well. I'm comfortable with [person] being there" and "[Person] can get very aggressive. The staff handle [person] very well. It is a godsend [person] is there." People's care plans documented any behaviour that challenged, triggers and how staff could work best with the individual to calm them down or prevent any inappropriate behaviour.

People told us that they felt that staff treated them with dignity and respect. One person told us "[Staff] is great, she comes down [to] our level and treats us well." We saw that when people required hoisting, staff explained what they were going to do before starting and talked with the person throughout to ensure that they felt safe and comfortable. Throughout the inspection, we observed staff knocking on people's door and waiting for permission before entering. Relatives also felt that people were treated with dignity and respect. One relative commented, "[Person] is incontinent and can get upset when this happens but, they are treated with dignity and respect." Another relative said, "[Person] is very private person and this has been respected."

Staff had a good understanding of equality and diversity and how this impacted on people's care. Staff

understood that homophobia was a form of abuse. We asked staff how they would work with people of differing cultures, sexualities and faiths. A staff member commented, "Everybody is human. It is their beliefs whatever it is, they are human and we have to help each other." Another staff member said, "Everybody is individual, it's about their preferences being met. Whoever they are and whatever their background."

People's religious needs were supported by the home. There was a visiting Christian priest that held regular services for people that wished to attend. One person had asked to be taken to church each week and we saw that this was being facilitated. The person said, "Every Sunday I go to church and someone goes with me." For another person that practiced a specific branch of Islam the home had contacted their mosque and we saw during the inspection that the person was receiving a visitor from their community.

Family involvement was evidenced throughout the care plans. For example, where one person had a DoLS application submitted their family were invited in to liaise with the service, with a view to participating in the process. Family members were also invited to be part of the care planning process. Feedback from relatives was positive and relatives told us that they had input and the home had asked them about their relative's preferences and likes / dislikes. Relatives had seen people's care plans. Where people were able, they were involved in the care planning process.

Throughout our inspection we observed family and friends visiting. Visitors were greeted warmly and made to feel welcome. We saw staff ask if people and their visitors needed anything and would provide tea and coffee if required. A relative said, "The place is lovely and they treat visitors well, ever so well."

Good

Is the service responsive?

Our findings

All people's care plans had been reviewed since the last inspection. Individual care plans were in place for people and had been created with their support needs in mind and set out how to support people to be well. Each care plan included a description and monthly reviews on topics including hearing, speech, comprehension, relationships and social interaction, dietary needs, oral care, washing and dressing, foot care, skin condition, medication, financial arrangements and end of life care. At the front page of each care plan was a one page profile that included a summary of an individual's background and skills, likes and dislikes, tips for communication, critical care and support needs and what was important for each person. Care plans were person centred and included a detailed section called, 'My background and skills'. This documented people's life history and what was important to them. For example, types of music, family relationships and childhood.

Each care plan also provided information around people's cognitive abilities, there was a section that documented people's decision-making ability and included, 'What I can still do' and 'what I find difficult'. This gave staff guidance on how to support people with decision making in the least restrictive way and how people could best be supported in their day to day lives. For example, one person's care plan stated, '[Person] is able to make some day-to-day decisions. For example, he is able to choose what to eat from the menu and what to wear. He can also choose where to spend his time and what to do during the day'.

People's communication needs were well documented in care plans. This included if the person required aids such as hearing aids or glasses. It also included information on how people communicated through gestures or sounds. This gave staff guidance on how to recognise if a person was distressed, happy or needing something if they were unable to effectively communicate verbally.

A relative stated, "They are hot on documentation. Everything has improved, the care plan covers all of the [person's] needs." We saw that each section of the care plans were reviewed monthly and reviewed as a whole every year. Where any changes were found, care plans had been updated.

The home had a dedicated activities coordinator. We saw that there were large posters around the home advertising activities including cinema club, arts and crafts, baking and exercise. The activities co-ordinator said, "I was able to make personal profiles on all the residents. This meant reading their care plans so I could differentiate and accommodate for them." There were daily activities for people to participate in, including quizzes, dancing, arts and crafts, movement to music, singing, bingo and gardening. One staff member said about a person, "He doesn't always participate but he clearly enjoys watching and observing others. He has come a long way." One family member said about the activities, "Little things have changed that make a big difference." A healthcare professional said of the activities, "The activities person is absolutely fabulous. She's got that caring approach." We observed activities throughout the inspection and people were seen to be smiling and singing. There was a happy, calm atmosphere throughout the home and some people that did not wish to engage in activities were seen to be observing. There was a poster on the door at the main entrance showing the activities for each day.

The garden was well cared for and provided a large area of outdoor space that people had access to. There were plants and herbs that had been newly potted and people were encouraged to take part in gardening activities. One staff member said, "She [activities coordinator] does them [pots] with the residents, they love it." The home had a hairdressing salon and a hairdresser regularly visited. People were able to make appointments when they wished.

Since the last inspection the home had created a small coffee shop near the entrance of the home. This was opened and staffed by volunteers every day and people were able to have coffee and snacks. One person told us that they preferred to spend time in the coffee shop rather than taking part with the activities and was quite happy doing that.

A written compliment from a relative said, 'I just want to say thank you for making mums 90th birthday so special. You went to a lot of trouble and mum thoroughly enjoyed the day'. A relative said, "There have been talks with the manager and I am pleasantly surprised about the place. [Person] is very private and staff have been very encouraging to get more socialising." Another relative said, "He sits here and watches what is going on. He may not get involved in all the activities, but they do try to involve everyone" Another relative said, "Staff have spent time encouraging [person], when there was a pub outing [person] went along."

The home had a complaints procedure that was available for staff and people to read and was displayed by the front door. This was in a larger font which made it easier for people to read. A pictorial, large font copy of how to complain was in the service user handbook. A copy of the complaints policy was also included. There had been two complaints in the past year. Complaints had been acknowledged, an investigation carried out and a response provided to the complainant. The manager told us that he felt that transparency and communication was "Very important." Relatives told us that they knew how to complain if they wanted to and felt that their concerns would be listened to. A relative said, "I would like to think [relative] knows who to complain to, I certainly do but he has never complained." Relatives also told us that minor issues were discussed with management and immediately addressed.

One person was receiving end of life care. We saw that the person had an advanced care plan in place. This documented the type of support the person needed, actions to be taken in the event of a significant deterioration in the person's health and healthcare professionals involved in the person's care. The family had also been consulted and their wishes noted. The person had been diagnosed with advanced dementia and had been unable to talk about their preferences at end of life. There was a best interest meeting involving the family, care home staff and healthcare professionals which documented decisions made and actions to be taken.

We saw that the home had medicines in place and ready to administer as and when necessary to ensure that the person was pain free and comfortable. A visiting healthcare professional told us, "They [the home] cope extremely well with end of life care. They let me know if there is a change in a person's character and their health is deteriorating." Where people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR), these were up to date and written in consultation with the family member and appropriate health professionals who had also signed it.

A compliment card from a relative whose family member had passed away noted, 'We would like to record our most sincere thanks to both [the manager] and all the staff at the care home for the way they looked after our dad. Showing him considerable respect, care, kindness, thoughtfulness and friendship." One family had donated a bench to the home's garden in recognition of the care the person had received and how they were supported at the end of their life.

Good

Is the service well-led?

Our findings

The manager was in the process of applying to CQC to become the registered manager. However, the manager knew the home well as he had managed the home several years before. Relatives told us," I am a stickler. I pick up on mistakes but I know [the manager] from before and trust him", "Recently things are more pro-active" and "Yes, I know who the manager is, and I can speak to him any time." Another relative described the management as, "A team work basis" and also said, "[The manager] has returned and [deputy manager] has been there a long time. Things have improved a lot. It is homely, but humble. There are more activities. There is more visual information, the building looks nicer, the garden looks better and everything seems more positive and dynamic." People were aware of who the manager was and we observed that people greeted him when they saw him.

There were regular audits completed that were used to quality assure various aspects of the home. Audits included checks of fire systems including fire extinguishers, fire alarms and fire door closures. There were monthly health and safety audits that checked the environment, people's bedrooms, water safety and maintenance. Housekeeping audits looked at cleanliness including all soft furnishings in communal areas and bedrooms. The home had a lead staff member for infection control and there was an infection control audit that also detailed a schedule for 'spring cleaning' each person's bedroom. There were daily weekly and monthly medicines audits. Where issues had been identified from audits, this was documented and appropriate actions taken.

Staff told us that they felt supported and received supervision and supervisions were documented in individual staff members files. However, the supervision matrix did not always reflect supervisions that were being held and this made it difficult to have oversight and ensure that staff were receiving the right amount of supervisions as per the home's policy of six per year. This was discussed with the manager who advised they would review their record keeping.

The home completed quarterly quality assurance and sought feedback from relatives, people, staff and healthcare professionals. We saw the Autumn 2017 quality assurance audit. The audit noted that this audit in comparison to the last one showed 'improved staff confidence in systems and structures' in place and staff morale was greatly improved. Relatives, people and healthcare professionals were positive about the home. One comment from a relative stated, "The staff are inspiring and always very well led." An action plan had been completed following the audit and we saw that all points had been addressed. This included décor, staff said that they would like more guidance and support when they reported any accidents or near misses and overall better access to support from senior management. The manager now conducted daily checks and incidents were discussed at staff meetings. A further audit in spring 2018 showed that the home continued to build positive working relationships with staff, relatives, people and healthcare professionals. A relative told us, "There are letters giving feedback, pictures up in the home and the laundry problems are dealt with."

The manager did a daily 'walk around' to complete visual checks of the home. Each day the manager checked and documented areas such as staff allocations for the day, a check of the controlled drugs, any

accidents, that people had access to call bells, any developing pressure ulcers and appointments. Any concerns identified were addressed immediately. This process ensured that the manager had a good oversight of the day-to-day running of the home. During the manager's daily checks, he spent time with people asking if there were any concerns or issues they may have. One person said, "He asks me if I'm okay and if anything is wrong." Records showed that the manager tested the food for flavour and quality on a regular basis to ensure that people were receiving good quality and meal experience.

There were regular documented staff meetings where staff were able to receive updates about the home, raise any concerns and share best practice. A staff member said, "Meetings are good. We talk about the residents, issues, good practice, [the nominated individual] attends. We talk about any problems. They listen to us and we can tell them anything."

The home held relatives' meetings where relatives received up-to-date information about the home and were able to raise any concerns. Relatives told us, "I attended meetings about the issues raised in the previous CQC reports. There are strengths and weaknesses that are being addressed" and "I go to meetings. lots of meetings since the poor CQC report. The meetings are not always well attended. Meetings are held at about 6pm, a problem for working relatives. I have my say." Other relatives that were unable to attend the meeting said that they did not always receive feedback from the meetings. One relative said, "I haven't received letters or information or feedback from the meetings. I would like to.' However, another relative told us, "I missed out on the relatives meeting but they been sent out letters. I'm happy with communication."

Healthcare professionals that we spoke with said that the home worked in partnership with them and were very open and transparent in their communication. One healthcare professional said, "It's [the home] got a nice warm feeling. Staff are very welcoming and they know they can call me anytime, and they do."

The home used incidents and accidents to learn. Following analysis of incidents and accidents measures had been put in place to address this and improve the quality of care. Result from surveys and audits also facilitated learning within the home and staff team. We saw that learning was shared with staff during staff meetings. One staff member said, "We learn from each other, it's continuous."