Kingsley Care Homes Limited

Downham Grange

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out a comprehensive inspection of Downham Grange on 11 July 2016. Following this inspection we served two warning notices for breaches of two regulations of the Health and Social Care Act 2008 relating to good governance and the management of people's medicines. In addition to this, we also found additional breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during that inspection. These breaches were in relation to person centred care, monitoring the quality and safety of the service and insufficient suitably qualified, competent and skilled staff to meet people's needs safely.

We undertook an unannounced focused inspection on 7 November 2016 to check that our warning notices had been complied with. At that inspection, we found that the provider had taken sufficient action to achieve compliance with the warning notices.

We undertook this unannounced comprehensive inspection 23 and 30 January 2017 to look at all aspects of the service, and confirm that the service now met legal requirements. At this inspection, we found improvements had been made in the required areas and the provider was no longer in breach of the regulations.

You can read the report for previous inspections, by selecting the 'All reports' link for 'Downham Grange' on our website at www.cqc.org.uk

Downham Grange is registered to provide accommodation for up to 62 older people who require nursing and personal care, some of whom may be living with dementia. On the days of our inspection, 51 people were living at the home.

There was a newly registered manager in post who had commenced employment at the home in October 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

During this inspection people said they felt safe and that staff treated them well. Safeguarding adults' procedures were in place and staff understood how to protect people from the risk of abuse. Risks associated with people's care were identified, assessed and recorded. There was a whistle-blowing procedure available and staff said they would use it if they needed to.

Policies and procedures were in place to guide staff with the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely by trained staff.

There were sufficient numbers of suitably qualified staff employed at the service. The provider's recruitment process ensured they only employed staff deemed suitable to work with people in a care setting. Staff had completed an induction programme when they started work and they were up to date with the provider's mandatory training.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that the registered manager was knowledgeable about when a request for a DoLS application would be required. Applications had been submitted appropriately to the relevant local authority.

Staff respected and maintained people's privacy. People received care and support as required and people did not have to wait for long periods before having their care needs met. This meant that people's dignity was respected and that their care needs delivered in a timely manner.

People's assessed care and support needs were planned and met by staff who had a good understanding of how and when to provide people's care whilst respecting their independence. Care records were detailed and up to date so that staff were provided with guidelines to care for people in the right way.

People were supported to access a range of health care professionals. Risk assessments were in place to ensure that people could be safely supported at all times.

People enjoyed a varied menu and had a range of meals and healthy options to choose from. There was a sufficient quantity of food and drinks and snacks made available to people.

Staff provided people with care in a respectful, caring, kind and compassionate way.

People were not always provided with enough activity and stimulation on a daily basis. The home had recently recruited an activities co-ordinator, but it was too early for this to have had an impact. Some staff engaged in meaningful conversations with people, but this was not consistent across all of the units in the home.

People's expressed preferences were not always met. Although staff knew what people liked, there were occasions when this was overlooked or assumptions wrongly made by staff, which frustrated people. Staff at times were task orientated and did not always confirm people's choices with them.

The service had a complaints procedure available for people and their relatives to use and staff were aware of the procedure. The registered manager took action to address people's concerns and prevent any potential for recurrence.

There was an open culture within the service and people were freely able to talk and raise any issues with the registered manager and staff team. Staff morale had greatly improved, they were motivated and felt proud to work at the home. The registered provider had ensured that the registered manager had been provided with the support and resources required in order to drive up quality at the home. The impact of this was that the home was now meeting its legal obligations.

People, staff and relatives were provided with several ways that they could comment on the quality of their care.

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.

There were arrangements in place to keep people safe from avoidable harm and abuse.

Risk management plans were in place to protect and promote people's safety.

There were sufficient numbers of suitable staff employed to meet people's needs safely.

People were supported by staff to take their medicines safely.

Is the service effective?

Good

The service was effective.

Staff were appropriately trained to carry out their roles and responsibilities.

People's consent to care and support was sought in line with current legislation.

Staff supported people to eat and drink enough to meet their needs.

Is the service caring?

Good

The service was caring.

Staff had developed positive and caring relationships with people.

Staff ensured people's privacy and dignity were promoted.

Staff promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received the care they required but not all were provided with opportunities to engage in meaningful activity or conversation.

People's expressed preferences were not always met. Staff sometimes made wrong assumptions about what people wanted.

There was a complaints procedure in place.

Is the service well-led?

Good

The service was well-led.

The registered manager was visible, people and staff felt that they were approachable.

There was a friendly, open and positive culture, which encouraged good communication.

The service had quality assurance systems in place, which were used to improve the service.

Downham Grange

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 unannounced inspection took place on 23 and 30 January 2017 and was carried out by one inspector, a medicines inspector and an expert by experience. An expert by experience is someone who has experience of using or supporting someone who uses this type of service.

Before our inspection, we looked at information we held about the service including notifications. A notification is information about important events, which the provider is required to tell us about by law. We also spoke with professionals from the local authority and clinical commissioning groups who had regular contact with the home.

During the inspection we spoke with seven people living in the home, three relatives and two visitors. We also spoke with the registered manager, deputy manager, the activities' coordinator and eight members of nursing and care staff. We spoke with the regional operations manager and service quality manager, both of whom represented the provider and were supporting the home on a regular basis. We observed how people received their care.

We looked at three people's care records, quality assurance surveys, staff meeting minutes and medication administration records and audits. We checked records in relation to the management of the service such as health and safety audits and staff training records.

Good

Is the service safe?

Our findings

At our previous comprehensive inspection in July 2016, we found that systems for monitoring and improving the quality and safety of the service were not operating effectively. We also found that people's medicines had not been safely managed. This meant there had been breaches of Regulations 17 and 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and we issued warning notices about this. We carried out a focused inspection in November 2016 to check if these had been complied with and saw that improvements had been made. At this inspection, we found sustained improvements and that the provider was no longer in breach of these Regulations.

People told us they felt safe in the home and were supported by staff who knew them very well. They said staff understood how to support them to maintain their safety, for example ensuring their walking frames were left near to them. Relatives told us their family members were safe and were supported by staff who had a very good understanding of their needs and how to ensure their safety. One relative told us, "I know that she's safe here and looked after."

Risks associated with people's nursing and care needs had been assessed. These had informed care plans that had subsequently been developed to guide staff on how to help keep people safe. These included risk assessments for maintenance of skin integrity, nutrition, mobility and falls. Actions had been put in place to reduce of the risk occurring. For example, medicines which may have a significant impact on people's risk of falls had been identified so staff were aware of this. A report of people's falls was entered in to their care records, which was used to monitor and identify any patterns in their falls. For people who lived with diabetes or special dietary needs, clear risk assessments and plans of care gave staff information on how to manage these risks. Updates to peoples care plans took place regularly so that information used was accurate. Staff shared this information at hand overs and senior staff reviewed this at a daily briefing. This meant any changes in people's health could be monitored and action taken if required.

For people who displayed behaviours that might present a risk to the person or others, the behaviours and triggers to these had been identified. Staff had a good understanding of people's needs and the risks associated with these behaviours. They told us how they supported people to remain calm, access other areas of the home and express their concerns whilst maintaining people's safety. The actions they discussed reflected the risk assessments and care plans for people. For example, one person became distressed if there were too many people in a room and the room was noisy. We saw staff spoke calmly with this person and supported them to move to a quieter area of the home during a busy time in the morning.

Incidents and accidents were reported and recorded at the home. The registered manager reviewed, logged and investigated any incidents and took action to try to reduce the risk of the event from re-occurring. This information was also sent to the registered provider's head office. The provider's quality team and regional operations manager reviewed these incidents. Discussion regarding these took place at leadership and staff meetings to explore any potential learning from them.

The registered manager ensured the management of risks associated with the premises took place. There

were fire and personal emergency evacuation plans in place for each person living in the service to make sure they received safe assistance whenever there was a need to evacuate the premises. We saw completed records of fire safety checks, water temperatures, refrigerator and food temperature checks. This helped ensure that the service was a safe place to live, visit and work in.

A member of Care Quality Commission, (CQC), medicines team looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

Medicines were being stored safely for the protection of people who used the service and at the correct temperatures. Records showed that people were receiving their medicines as prescribed. There were frequent internal audits in place to enable staff to monitor and account for medicines. There were improvements in the availability of prescribed medicines and the home promptly obtaining people's medicines. The registered manager took action in response to identified errors in an attempt to reduce the risk of them occurring again in the future.

Supporting information was available when people received their medicines. This enabled the staff handling and giving people their medicines to do so safely and consistently. There was personal identification and information about known allergies/medicine sensitivities and written information on people's preferences about having their medicines given to them. For people with medicines prescribed on an as and when required basis (PRN), written information was available to show staff how and when to give people these medicines. Staff completed charts that were in place to record the application and removal of prescribed skin patches. This ensured that used patches were removed before applying a new one.

When people were regularly refusing their medicines, the home had taken action to review their medicines with their doctor. For people with limited capacity to make decisions about their own care or treatment and who refused their medicines, there were records of assessments showing they lacked mental capacity. This included their doctor's approval to give them their medicines given to them crushed in food or drink (covertly). However, there was insufficient information available for staff to refer to about how and which medicines should be given to people in this way to ensure that staff gave the medicines consistently and appropriately. We spoke to the registered manager about this who agreed to review this.

Staff had a good understanding of the safeguarding policies and procedures that were in place to protect people from the risk of abuse and avoidable harm. Staff had received training on safeguarding and knew the types of abuse they may witness. Staff knew how to report this both in the service and externally to the local authority or CQC. Staff were confident the registered manager would deal with any concerns they raised swiftly and they were aware of the registered provider's whistleblowing policy. The registered manager had reported any incidents of alleged abuse to the local authority safeguarding team, and had notified the CQC. We were therefore satisfied that the provider had systems in place to help protect people from the risk of abuse.

There were sufficient staff available to keep people safe. The registered manager told us that a recent recruitment campaign had been successful meaning that the service was fully staffed. Staff rotas we looked at showed there were consistent numbers of staff available each day to meet the needs of people. Staff we spoke to said that staffing levels were good. One senior support worker told us that in one particular unit, people's needs had changed meaning that staff were starting to struggle to meet their needs. They told us that they had discussed this with the registered manager, who increased the number of staff on duty in this unit. The registered manager used a recognised dependency tool, which they used to calculate how many staff were required to support people at different times of the day.

Relatives and staff told us there were always sufficient members of staff on duty at any time to meet the needs of people and our observations confirmed this. However, we observed that the deployment of staff at mealtimes led to an inconsistent experience for some people. In one dining area, where people required little support, there was the same number of staff as another dining area, where a greater number of people were eating. The people eating in this dining area also required a greater level of support. We brought this to the attention of the registered manager who told us that they were aware of this and were currently reviewing the dining room arrangements. They said that the number of people choosing to eat in this room had declined. Plans were in place to extend the smaller dining room, in which most people living with dementia where choosing to eat.

We observed requests for support responded to in a timely way and people we spoke to confirmed this. People told us that at certain times of the day, they had to wait longer for support, but that this wait was not unreasonable. We saw call bells answered in a timely manner during our inspection and we looked at records that confirmed this to be the case at other times.

There were robust methods in place to ensure that the staff recruited to work in the home were safe to do so. Recruitment records included proof of identity, an application form and employment history for people. Two references were sought before staff commenced work at the home, Disclosure and Barring Service (DBS) checks were in place for staff in the records we looked at. These help employers minimise the risk of unsuitable staff working with people who use care and support services. Staff could only start work when these checks were completed.

Good

Is the service effective?

Our findings

At our last inspection in July 2016, we found that staff had not received the training and support they needed in order to be competent to meet people's needs safely. This meant there had been a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We told the provider that improvements needed to be made in this area. At this inspection, we found that improvements had been made, and that the provider was no longer in breach of this Regulation.

People's relatives told us that they felt staff were well trained and knew how to support people. A relative of a person we spoke with said, "There are some very good staff, staff know what they are doing, [relative] is well cared for."

A robust program of supervision sessions, induction and training was in place for staff. This ensured people received care and support from staff with the appropriate training and skills to meet their needs. Staff felt supported through these sessions to provide safe and effective care for people. Staff told us that they were now given the time to undertake and complete training. One member of staff told us how much this had motivated them. They had recently completed a training course in supporting people living with dementia. They said, "I can't believe how much I have learned about dementia, it means I can do a better job at caring for the people living here now."

The deputy manager was a mentor for nursing staff and supported them in developing skills and ensuring they were up to date with practice to meet the requirements of their registration with the Nursing and Midwifery Council (NMC). Nursing staff told us that they felt well supported as a nurse. One nurse told us, "There has been an improvement in training and development, we are now getting clinical specific training, and [deputy manager] is very supportive."

Records showed staff had access to a wide range of training which included but was not limited to: moving and handling, fire training, safeguarding, mental capacity and deprivation of liberty, principles of care and health and safety. All staff had been encouraged to develop their skills with external qualifications such as National Vocational Qualifications (NVQ), Care Diplomas and the Care Certificate. These are work based awards that are achieved through assessment and training.

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.

Care records provided clear information on the decisions people were able to make, and those with which they required the involvement of others. Records identified relevant individuals to involve in best interests decisions including relatives, legal representatives and healthcare professionals. Care records showed staff respected people's choice when receiving care. For example, if people did not always want to have support

with personal care staff would respect this wish, then return to the person later, and ask if they needed any support.

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 application procedure for this in care homes is called the Deprivation of Liberty Safeguards. For most people who lived at the home an application had been made to the local authority with regard to them remaining at the home to receive all care or leaving the home unescorted. We found the home to be meeting the requirements of Deprivation of Liberty Safeguards authorisations in place.

People enjoyed a variety of freshly prepared foods of their choice. The cook showed us a six week rolling menu which they used to provide a wide variety of nutritious meals for people. We saw people given choice daily as to their preferred food option and alternatives were available. However, we did note that one person was given a meal that they had not chosen. The person was a vegetarian and they were brought a meat dish. When the person's relative pointed this out, it was quickly rectified. We also saw the daily menu written on a chalk board in each of the dining rooms, to remind people of the choices on offer. On the first day of our inspection, the board had not been updated for three days. We pointed this out to the registered manager who took action to address this.

Special diets such as those for people who lived with diabetes, who required gluten free, pureed or soft diets were catered for. Staff monitored people's daily intake to ensure they had an adequate nutritional intake. Care plans identified specific dietary needs, food likes and dislikes and the cook was aware of these. People's weights were monitored regularly and action taken should any significant changes be noted. A relative of one person told us that their relative, "Loves the food, as soon as they know its mealtime they are up to the table." The relative went on to tell us that they were pleased their relative had gained weight. For people who were at risk of choking, information in care records clearly identified the need for staff to thicken fluids to reduce this risk.

Equipment such as plate guards and beaker cups were available for people to encourage them to be independent with their meals. One person told us, "The food is lovely, they bring us a form with the choices and we can decide." For people who remained in bed, staff supported them to manage their meals independently, positioning them well in bed and allowing them to do as much as possible themselves, whilst offering encouragement and support. Snacks were available for people, including bowls of fresh fruit. Where people were living with dementia, and deemed to be at risk if they ate without supervision, staff asked people if they wanted a snack and brought this to them.

Records showed health and social care professionals visited the service as and when required. Care records held feedback from GP's, speech and language therapists, social workers and a tissue viability nurse. Staff identified people's needs and involved health and social care professionals appropriately. Feedback we received from health and social care professionals showed that standards at the home had improved since our last inspection. They told us the communication between the home and their services was effective and they had confidence that people received appropriate healthcare.

Good

Is the service caring?

Our findings

People were valued and respected as individuals and were happy and content in the home. They told us that they were happy with the care provided by staff. One person told us, "They're all very nice." Another person said, "They are very good." Most relatives we spoke with told us that they were pleased with the care provided at Downham Grange. One relative told us, "I'm amazed by this place, all the carers are so caring and can't do enough for people."

Staff knew people well and supported each person as an individual. They addressed people by their preferred name and spoke with them in a way that was meaningful and supportive to them. Staff greeted people politely and enthusiastically when seeing a person for the first time that day. They asked people how they were and if they had slept well. Staff who had been off duty for a day or more, conversed with people about what they had been doing. Staff had a detailed understanding about people's life histories, their families and interests. This meant that they could engage in conversation in topics that interested them.

People were able to express their views and be actively involved in making decisions about their care. The registered manager told us it was difficult to have meetings with all people who lived at the home due to their understanding and abilities to concentrate and communicate. They said that a small group of people did attend meetings on a regular basis. We saw in people's care plans, that where people could, they were asked about how they wanted to be cared for. People were also involved in the review of their care.

The atmosphere in the home was calm and friendly. Staff were caring and unhurried in responding to people's needs at all times. People were encouraged to be as independent as possible and were able to move around the area of the home they lived in as they chose. People were prompted to use their walking frame, and given encouragement and support when doing so. Staff gave people directions, for example to where the dining area was, in a polite and supportive manner, if they became confused. We saw one person supported by a staff member to eat a snack of grapes independently. The staff member knew that the person was able to use one arm very well. They ensured that the table, on which the plate of grapes was placed, was on the correct side and at the right height so that they could help themselves.

Staff had a good understanding of the need to treat people with respect at all times. Doors remained closed to people's rooms when they were being supported with personal care and staff knocked and waited for a response before entering people's rooms. Staff had a good understanding of how to promote and maintain people's dignity. One staff member told us that it was important to be organised before supporting people with personal care, for example ensuring that clothes, towels and toiletries were to hand. They said that this helped to make the experience as enjoyable and dignified as possible. They also told us they asked people what they wanted to wear, because, "everyone feels better when they look their best."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in July 2016, we found that people did not always receive care that took into account their individual needs and preferences. This meant there had been a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We told the provider that improvements needed to be made in this area. At this inspection, we found that improvements had been made, and that the provider was no longer in breach of this Regulation. However, we found that further improvements are needed in the provision of activities as well as ensuring people's choices are always promoted.

An assessment of people's needs was made before they came to live at the home. These assessments helped to inform care plans for the person and records showed that people and their relatives were encouraged to be a part of this process. People's preferences, their personal history and any specific health or care needs they had were documented.

Staff had a good understanding of the need for clear and accurate care plans which reflected people's needs. Care plans gave detailed information for staff on how to meet the needs of people in a person centred and individualised way. For example, they provided clear information on how to support people with their personal care and encourage their independence. They were also specific to people's individual health conditions such as diabetes. Staff told us they accessed care plans to help them have a good understanding of people's needs.

However, we observed on some occasions, that peoples expressed preferences were not always met and had not been offered choices. Staff sometimes wrongly made assumptions about what people wanted. For example, during a mealtime in the Cygnet Unit, drinks had already been poured for people before they arrived at the table. No choice was given. We observed that one person, before they sat down, ask staff why they had been poured that particular drink when it was known that they did not like it. The staff member they spoke to apologised for this, and then checked with the person what they would like to drink. We also saw one person specifically ask for a small portion of lunch. However, when their meal arrived, it was a regular sized portion, which made them unhappy. They also stated that there was no salt and pepper on the table, which they said staff knew was something they always wanted with a meal. Both of these issues were quickly addressed when pointed out by the person, who by this point, had become frustrated.

One person we spoke with told us, "We've been getting up later in the morning," and explained that they had been supported to rise at around 9am instead of their preferred time of 8am. Another person told us that she was supported to bed in the evening between 8.30pm and 9pm, but their preferred time would be to go at 10pm. All of the other people we spoke with told us that the preferred times of rising or going to bed were met. One relative we spoke with told us that they felt improvements could be made in their relatives care. They said they felt that at times the quality of care had been inconsistent, and that they had raised this with the registered manager. We asked the registered manager about this, who told us that they were working with the person's family to improve their experience. This meant that although people's preferences had been identified, staff did not always ensure that they were met.

External entertainers visited the home and included musicians and singing acts. We saw that day trips to the seaside and a local pub had been enjoyed recently. On both days of our inspection, the activities co-ordinator had arranged for activities to take place with a small group of people. However, there was not yet a regular daily schedule of activities in place that people could look forward to and plan for. Equipment such as art and crafts, reminiscence objects or card games were not available except in the lounge that was used for some activities. Tables that people were sitting at did not have items that could interest or stimulate them.

We found that although there were enough staff available to meet people's needs including activities and engagement, staff were not always proactive in doing this. In the Drake unit, which supports people living with dementia, we saw staff speaking with people and asking them how their relatives were after they had been to visit. For people who remained in their rooms, staff observed them at regular intervals and recorded this interaction. We saw staff interacted kindly and gently with people who had limited communication and remained in bed. However, staff did not always sit and have a conversation with people, even when they had time. On some occasions, we saw that staff had conversations amongst themselves, rather than talk to people living in the home. On other occasions, staff enthusiastically engaged with people in conversation. We concluded that the opportunities for people to engage in conversation were varied and reliant upon the actions of individual members of staff rather than an ingrained approach from all staff.

Some people's relatives expressed dissatisfaction with the lack of interesting things to do, one relative said, "There is very little to do here." We spoke to the registered manager about the lack of activities that took place in the home. They told us that they recognised this as being a problem, but that due to successive activity co-ordinators not staying in post over the past twelve months, it had been difficult to make sustained progress in this area.

They told us that an experienced member of care staff had now filled this post, and that they were in the process of transferring to their new role. They expected them to be in post on a full time basis within the following month. We spoke with this member of staff, who told us that although they had not undertaken this type of role before, they were motivated and excited by it. They told us that they had some ideas, and would be speaking with people living at the home to find out what sort of activities they would like to do.

The complaints policy was displayed in the entrance to the home. We saw any concerns or complaints were investigated and actions from these were implemented. Records showed recent concerns or complaints had been addressed. The registered provider monitored all complaints and concerns reported. They worked closely with the registered manager to ensure the appropriate management of these.

Staff were encouraged to have a proactive approach to dealing with concerns before they became complaints. Staff welcomed visitors in a warm and friendly way and relatives felt able to express their views or concerns and knew that these would be acted upon effectively.

Good

Is the service well-led?

Our findings

At our previous comprehensive inspection in July 2016, we found that systems for monitoring and improving the quality and safety of the service were not operating effectively. This meant there had been a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and we issued a warning notice about this. We carried out a focused inspection in November 2016 to check if this had been complied with and saw that improvements had been made and the provider was no longer in breach of these Regulations. At this inspection, we found that these improvements had been sustained.

Relatives felt the leadership of the home had improved since the registered manager started in post in October 2016. They told us that the registered manager and deputy manager were approachable, and listened to their concerns. Some relatives also told us that they found senior managers from the providers head office supportive and willing to listen to suggestions for improvement. However, some people's relatives and visitors told us that there was less management and leadership of the home at weekends. They told us that this created a, "different feel", and that staff were not as proactive at weekends. We looked at rotas of when senior staff and managers worked at the home. We saw that both the registered manager and deputy manager regularly worked at weekends, and that a senior member of staff was on duty every weekend.

There was a clear leadership and staffing structure in place at the home which was supported by further managers at the registered provider's head office. A robust network of support for all staff was evident in the home. Staff told us that this had been a significant area of improvement since our last inspection. The registered provider had clear systems and processes in place to ensure the safety and welfare of people. The regional operations manager for the registered provider visited the service very regularly. This provided support to the registered manager and their deputy and this ensured a stable senior management team in the home. A business manager and administrator in the home supported with all clerical duties, this allowed the registered manager to focus on service improvement and development. Registered nurses supported the deputy manager, who was the homes clinical lead, with the clinical day-to-day running of the home.

There was an open culture in the home. Staff told us they were able to speak with the registered manager, their deputy or registered nurses about any concerns they may have and felt these would be addressed promptly and effectively. They knew the regional operations manager for the registered provider visited regularly and felt they were supportive of the work they did at the home. Staff spoken with demonstrated a high level of motivation and commitment to the people they supported. They had a clear understanding of their roles and what was expected of them. They were enthusiastic in the way they described their work and how much they enjoyed it. They described teamwork as good and the management team as supportive in encouraging them.

Staff felt supported through supervision, appraisals and team meetings. These were used to encourage the sharing of information such as learning from incidents, changes in documentation following review of care plans or records and new training and development opportunities. Staff told us they had been provided with whistleblowing training and that it was a regular agenda item at staff meetings. All the staff we spoke

with were confident if they raised a concern it would be investigated appropriately by the registered manager in line with the provider's procedure.

The registered manager received support from the registered provider, who they said was determined to improve the quality of service provided to people living at Downham Grange. They told us that support and resource was provided to do this, including regular visits from their service quality manager. A robust programme of audits was in place at the home to ensure the safety and welfare of people, including audits, which were completed by managers from the registered provider's head office. Audits to ensure the safety and welfare of people included: medicines, infection control, the environment, equipment checks and fire records. These audits were reviewed with the regional operations manager with action plans completed.

Registered nurses and senior support workers reviewed care plans and records monthly. Since our last comprehensive inspection in July 2016, the registered manager and deputy manager now compiled a trend analysis of particular incidents. This included people's falls, incidents, accidents, and feedback about food. We saw that the analysis of peoples likes and dislikes of meals food, was now used in menu planning. This helped the home determine which choices of meals served were popular with people living with dementia. The deputy manager told us attempts to obtain feedback by other means, such as surveys, had not been successful in the past.

People, their relatives and their visitors were asked for their views of the service and the quality of the care delivered at the home. This took place via an electronic questionnaire that people, relatives and visiting health professionals could complete on a tablet device located in the reception area of the home.