Beaumont Nursing Home Limited

Downlands

Inspection report

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Date of inspection visit:
08 May 2018

Date of publication:
05 September 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 8 May 2018 and was unannounced. Downlands 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 accommodates up to 23 people in one adapted building. The provider is registered to support older people and people with disabilities. The service offers long term or respite care. At the time of the inspection there were 16 people living at the home and nobody was receiving short term respite care.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the manager at Downlands had applied to become the registered manager. Shortly after the inspection the application process was completed and they were confirmed as the registered manager. They were present throughout the inspection.

When we completed our previous inspection on 11 April 2017 we found concerns relating to safe care and treatment. This was because risks to people were not always identified, assessed and managed effectively. After the inspection the provider sent us an action plan describing what they had done to ensure compliance with the legal requirements. At this inspection, on 8 May 2018, we found that the provider had followed their action plan, risks were being managed safely and the breach of regulations had been addressed.

People told us they felt safe living at Downlands. One person said, "Help is there when we need it. I never feel worried." There were enough staff on duty to care for people safely. There were safe recruitment procedures in place and staff received an induction when they started working at the home. People were receiving the medicines they needed and staff demonstrated an understanding of their responsibilities to safeguard people. The home was clean and there were effective systems in place to prevent and control infection. Incidents and accidents were recorded, together with details of what actions had been taken, to prevent a recurrence, where possible. Learning from incidents was used to make improvements at the home.

Staff spoke positively about the training and support they had received. People and their relatives told us they had confidence in the skills of the staff. One relative said, "I am very happy with the staff, they know what they are doing and I feel my relation is in good hands." Staff supported people to have access to health care services. They reported effective arrangements for working in partnership and advice from health care professionals was included within people's care plans. People's diverse needs had been assessed holistically and staff ensured that there was proper consideration of consent before providing care and support to people. People were supported to have the maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. People were happy with the food and said they had a choice of what to eat and drink.

People were treated with kindness and respect. One person told us, "I don't feel rushed, the staff are very respectful and always kind." Staff supported people to be involved in planning their care. People were encouraged to be as independent as possible and their dignity was protected. One person said, "All the staff are great."

Staff knew people well and provided care in a personalised way. People's care plans were reviewed regularly and updated when things changed. People and their relatives knew how to complain and said they were confident that any concerns would be addressed. People were supported to make plans for the end of life.

People, their relatives and staff spoke highly of the management of the home and described the registered manager as, "approachable" and "efficient." There were effective systems in place to monitor quality and drive improvements at the home. We noted that improvements made following previous inspections had been sustained and were embedded within staff practice.

There was clear leadership and staff understood their roles and responsibilities. Staff described positive communication both within the staff team and with other agencies. Staff meetings were held and staff confirmed their views on developments at the home were welcomed.

The overall rating for the home had improved to Good.

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.

Risks were identified, assessed and managed to ensure people were safe.

Environmental risks and infection control procedures were managed effectively.

Recruitment processes were robust and there were enough suitable staff to care for people safely. Staff understood their responsibilities for safeguarding people.

People were receiving their medicines safely.

Is the service effective?

Good

The service was effective.

People's needs were assessed in a holistic way. Staff had received the training and support they needed to be effective in their roles.

Staff understood their responsibilities with regard to the Mental Capacity Act 2005.

People were receiving enough food and drink. Staff supported people to access the health care services they needed.

Is the service caring?

Good

The service was caring.

Staff were gentle and caring. People's emotional needs were supported.

Staff knew people well and encouraged them to be involved in planning their care.

Staff were respectful and protected people's dignity. People were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People were supported in a person-centred way. People had enough to occupy them. Staff noticed changes in people's needs.

People's complaints were listened to and action was taken to address their concerns.

People were supported to plan for care at the end of their life.

Is the service well-led?

Good

The service was well-led.

There were effective systems in place to monitor the quality of care and to drive improvements. Positive changes had been sustained and were embedded within practice. Staff and people were engaged and involved in planned developments.

There was visible leadership and staff were clear about their roles and responsibilities.

There was effective communication both within the home and with other agencies. Staff had made positive contacts within the local community.

Downlands

Detailed findings

Background to this inspection

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

This inspection took place on 8 May 2018 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On this occasion we did not ask the provider to submit a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at information we held about the service. This included any complaints we had received and any notifications. Notifications are changes, events or incidents that the service must inform us about. We contacted the local authority for their feedback before the inspection and received a copy of a health and safety review dated 23 February 2018.

During our inspection we spoke with nine people, three relatives and one visitor. We spoke with six members of staff, and the registered manager. We observed staff interactions with people. We reviewed a range of records about people's care and how the service was managed. These included the care records for four people, medicine administration record (MAR) sheets, three staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service.

The service was last inspected on the 11 April 2017 and was awarded the overall rating of Requires Improvement.

Good

Is the service safe?

Our findings

At the last inspection on 11 April 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because risks to people were not always identified, assessed and managed effectively. After the inspection the provider sent us an action plan describing what they had done to ensure compliance with the legal requirements. At this inspection on 8 May 2018 we found that the provider had followed their action plan, risks were being managed safely and this breach of regulations had been addressed.

Risks to people were identified, assessed and managed. Some people were living with long term conditions such as diabetes, dementia, Parkinson's disease and mental health problems. Risk assessments and care plans were in place to assess risks associated with these specific conditions. There were clear plans in place to guide staff in how to minimise risks and support people. For example, some people were at risk of developing pressure sores. Tissue viability care plans were in place and provided detailed guidance for staff in how to reduce risks to skin integrity. This included details of equipment that was needed to support the person and guidance in how and when to support the person to move or change position. One person had developed a pressure wound and a wound-care plan was in place. Advice had been sought from a Tissue Viability Nurse (TVN) and this was included within the wound care plan. Records showed that staff were following the care plan and assessing the wound on a daily basis. A pain control care plan was also in place to ensure that the person received appropriate pain relief.

Where possible people were included in decisions about taking risks. For example, one risk assessment identified that the person's condition fluctuated. The care plan took account of this and guided staff in how to identify, with the person, the level of support they required. This meant that the person was supported in a safe way, that minimised restrictions on their freedom.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks on equipment and the fire detection system were undertaken to ensure they remained safe. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Gas, electrical, legionella and fire safety certificates were in place and renewed, as required, to ensure the premises remained safe. People's ability to evacuate the building in the event of a fire had been considered and each person had an individual personal evacuation plan (PEEPs). Fire drills were regularly undertaken, including at night, to ensure that staff were familiar with the process of evacuating the building in an emergency.

Infection prevention and control procedures were in place and we observed staff were using appropriate personal protective equipment (PPE) when supporting people with personal care. We noted that all areas of the home were clean and tidy. Some areas of the home had been renovated, including the downstairs bathroom. The registered manager told us that plans were in place to continue renovations, including replacing carpets and decorating hallways which were in need of a refresh. Staff had taken part in a recent hand-washing challenge which was designed to remind staff about the importance of maintaining safe hygiene standards. Checks were undertaken to ensure that equipment was being cleaned regularly, in line

with the provider's policy.

People were receiving their medicines safely from staff who were trained to administer medicines. Records were completed consistently. Some people had been prescribed medicines to be given PRN (as required). There were clear protocols in place to guide staff in when and how to administer these medicines. Some people were using medicated patches and application records were completed to show the position of each patch. There were safe systems in place for the management, storage and disposal of medicines.

People told us they felt safe living at Downlands. One person said, "Help is there when we need it. I never feel worried." Another person said, "There is always staff around, the place is very safe, I feel relaxed about that." A relative said "I am very happy with the home and the staff, I feel people are safe here." A visitor told us that staff were welcoming but did question visitors. They explained, "They check you out, I think that's a good thing and shows they are looking out for the people here."

Staff demonstrated a clear understanding of their responsibilities for safeguarding people. They had received training in how to recognise signs of abuse. One staff member said, "If I had any concerns I would report them to the manager." Another staff member said, "If I saw poor practice or thought something wasn't right I would report it straight away, I'd have no hesitation." Records confirmed that safeguarding concerns had been raised appropriately, in line with the provider's policy. Staff also told us about the provider's Whistle-blowing policy. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations.

There were enough staff on duty to care for people safely. The provider used a system to assess the dependency of people so that staffing levels were appropriate to meet people's needs. Staff told us that staffing levels were maintained. One staff member said, "I think the staffing levels are good, you don't have to rush people, it's busy but not too much pressure." People told us their call bells were usually answered in a timely way. One person said, "We have to wait awhile sometimes but usually it's fine." People told us, and we saw, that call bells were left within reach to ensure that people could summon help if needed. Throughout the inspection we observed that staff were able to respond to people's call bells and people did not have to wait longer then they should expect for their care needs to be met. Records of staff rotas confirmed that staffing levels were maintained. There was some use of agency staff to cover for vacancies or staff absence but this was minimal. The registered manager told us that they endeavoured to use the same agency staff where possible to maintain continuity for people. They explained that they were currently recruiting to one vacant post.

Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work, which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form. Files contained evidence to show where necessary, staff belonged to the relevant professional body. Documentation confirmed that nurses employed had up to date registration with the Nursing and Midwifery Council (NMC).

Incidents and accidents were recorded and the registered manager checked that appropriate actions were taken. They told us that patterns were sometimes evident, which required additional attention. For example, it had been noted that one person had a number of falls and they had occurred during periods of increased agitation in the afternoon. By ensuring the person received individual support from a member of staff during the afternoon, their agitation had reduced and no further falls had occurred. This showed how lessons had

been learnt to improve the safety of this person.

Good

Is the service effective?

Our findings

At the last inspection on 11 April 2017 we found that staff understood the principles of the Mental Capacity Act 2005 (MCA). However, there was not a consistent and clear approach to determining whether people had capacity to make decisions about their care and undertaking best interest decisions where needed. We identified this as an area of practice that needed to improve. At this inspection on 8 May 2018 we found that the provider had made improvements, staff had received training in MCA and records confirmed that appropriate assessments had taken place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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 or authorisations to deprive a person of their liberty were being met.

Staff demonstrated that they had a firm understanding of they responsibilities with regard to the MCA. Throughout the inspection we observed that staff were checking with people before providing care and support. For example, a staff member was heard asking one person, "May I help you to sit up?" The person declined and said they didn't want to move. The staff member respected their wishes and said they would come back later. The staff member explained, " We can't force anyone to do things against their wishes."

Where people were unable to make decisions for themselves staff had considered the person's capacity, under the MCA and had taken appropriate action to arrange meetings to make a decision within their best interests. For example, some people were receiving support in a way that could restrict their freedom to move around, such as with the use of bed rails or lap straps. Where people were able to consent this was recorded. Where it was felt people may lack capacity to consent, appropriate mental capacity assessments were in place. Records showed details of how decisions had been made in the best interest of the person, including identifying the least restrictive options and identifying when the decision would be reviewed. Appropriate referrals had been made for Deprivation of Liberty Safeguards (DoLS) and we could see that staff understood how these were implemented. DoLS authorisations had been granted for some people, staff knew this and were aware of their responsibility to comply with these authorisations when providing care.

People's needs and choices had been assessed in a holistic way to take account of people's physical and mental health and their social needs. Appropriate assessments were undertaken to identify how to achieve effective outcomes for people. For example, following unplanned weight-loss one person had been assessed for risks of malnutrition using an accredited tool in line with good practice guidance. A referral had been made to a dietician and their recommendations for, "food as treatment," were included within a nutritional

care plan for the person. This meant that staff were informed about how to increase the calorific intake of the person, although they were eating small amounts and this helped to reduce the risk of further weight-loss.

The provider's policy on equality and diversity included clear statements about how staff should respond to people's diverse needs and consider equality and human rights in every aspect of their work. Staff demonstrated an awareness of the policy and understood their responsibility with regard to ensuring that people were protected from discrimination. One staff member said, "This is a very positive place to work. We make sure people are treated very well, according to their different needs." They gave an example about staff supporting someone for whom English was not their first language and explained how staff had learned key words and phrases, to be able to offer reassurance to the person, when needed. One person with particular religious needs was supported to use technology to access a religious ceremony on a weekly basis. Staff said the person was offered the choice of being taken to the event, or using the telephone link to take part. They had chosen to listen into the service from their room.

People and their relatives told us they had confidence in the staff. One person said, "They know how to look after us, I think they are well trained." A relative said, "I am very happy with the staff, they know what they are doing and I feel my relation is in good hands."

Staff had received training in subjects that were relevant to the needs of the people they were supporting. For example, records showed that training had included dementia awareness, end of life care and dignity and empowerment. Some staff were undertaking the care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff said they felt well supported in their roles and described having regular supervision meetings. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. Records confirmed that staff were attending supervisions meetings and that competency checks were in place to ensure they had the skills, knowledge and experience they needed for their roles. New staff were supported with a period of induction to orientate them into their role. One staff member said, "I was shown what to do and given time to see people's routines. I worked alongside a permanent member of staff until I felt confident."

People were being supported to have enough to eat and drink. One person told us the meals were good and said, "There are normally four or five choices and they are always asking if you want a drink." We observed the chef talking to people about what they would like to eat and discussing the menu which was on display in the dining area. The chef told people, "I'm cooking your lunch today, what would you like?" People said this happened every morning. One person told us, "There's a good choice of meals, I can have what I want." The chef said that a system was in place to gather people's feedback and views about the food and drink on offer. The chef was aware of people's personal preferences and nutritional needs and said that care staff and nurses communicated any changes to the kitchen staff.

Risks associated with eating and drinking had been identified and assessed. Appropriate referrals were made to obtain specialist advice about how to support people and reduce risks. For example, a person had been identified as having difficulties with swallowing. They were referred to a Speech and Language Therapist (SALT) who recommended thickened fluids and a pureed diet. The person's care plan was updated to reflect this advice and we observed that staff were aware of the support that this person needed. Care records identified that some people were living with diabetes. We observed that staff were aware of this

and knew how to support people, who were living with diabetes, to ensure they were still offered choice, while maintaining a healthy diet.

One staff member told us about a positive meal time project that staff had been working on in partnership with the Care Homes In-Reach Team (CHIRT). They explained that staff had attended a training workshop with CHIRT and reflected on how they could make a difference to people's quality of life, by improving their meal time experience. This focussed on a number of ways to increase opportunities for people to make choices and have control. For example, drinks and snacks were available for people to help themselves in the dining area. Specialist cutlery had been provided for some people, who were living with dementia, to support them to eat independently. Staff said that they were aiming to make meal times more of an occasion for people. We noted that the dining area was made to look attractive and tables were set with table cloths, flower arrangements and condiments. People told us that they had noticed a difference and comments included, "The staff make a real effort to make it nice for us."

People and their relatives said that staff supported them to access the health care services they needed. One relative told us, "Staff noticed very quickly when my relation was unwell and called the doctor." People were supported to attend health care appointments. For example, one person had a hospital appointment on the day of the inspection and a staff member accompanied them. They told us, "The staff help me to get ready and know what time I have to leave so I don't have to worry." Staff described positive relationships with health care professionals, including the GP, who visited people regularly. Records confirmed that people were able to access support for routine appointments including with a dentist, chiropodist and optician. Where appropriate, referrals had been made to a range of health care professionals such as physiotherapists, occupational therapists, SALT, tissue viability nurse (TVN) and community psychiatric nurse (CPN).

The premises was suitable to meet people's needs. People who were able to move around independently or with support, told us that they could access the garden and used a lift to move between floors at the home. Adaptations had been included to meet peoples needs. For example the downstairs bathroom had been refurbished and included hand rails, raised toilet seat and an accessible bath. Some areas of the home had been redecorated and the registered manager told us about plans to replace warn carpets and decorate hall ways throughout the home.

Good

Is the service caring?

Our findings

At the last inspection on 11 April 2017 we found that the service was not consistently caring because people's dignity was not always respected. We identified this as an area of practice that needed to improve. At this inspection on 8 May 2018 we found that improvements had been made and people were consistently treated in a respectful way and their dignity was protected.

People were supported in a discreet way to protect their privacy and dignity. For example, when someone needed assistance in the lounge area a staff member used a screen to protect their privacy whilst their clothing was adjusted. Another staff member was observed speaking to someone discreetly about their medicine. They spoke quietly and respectfully to the person to avoid drawing other people's attention. Staff routinely knocked on people's doors and waited for a response before entering the room. A staff member was observed spending time with a person to check how they were. They took a gentle approach, supporting them with a drink and checking patiently how the person was feeling. The interaction was kind and respectful with the staff member giving the person their full attention and not rushing them at all.

People told us they felt staff supported their dignity. One person said, "They help me to get dressed and take time to make sure I'm happy with what I'm wearing. I don't feel rushed, the staff are very respectful and always kind." People's differences were acknowledged and respected. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. For example, one person was wearing jewellery that matched the colour of their top. A staff member told them how nice they looked, the person was clearly pleased with the compliment.

People were supported to be as independent as possible. One staff member explained, "I also encourage people to do what they can, if they feel able to. It's important to build their confidence and support them to remain independent." A staff member described how staff had worked in partnership with a physiotherapist to successfully support a person to regain their mobility and improve their independence. Care plans guided staff in how to support people to retain their skills and identified skills they could loose if not actively encouraged.

Staff demonstrated an understanding of the importance of respecting people's confidentiality and their personal records were kept securely. Staff had received training in dignity and respect and a regular meeting had been introduced for staff to discuss and reflect upon how they can improve their practice with regard to supporting people's dignity.

People spoke highly of the support they received from staff. One person said, "There is not a bad one here, they are all good." Another person said, "All the staff are great." Relatives told us, "If I wasn't happy with the care I would move my relation, it's a good place," and, "The staff are all kind and caring."

Staff knew people well and understood their needs. One staff member told us, "The staff all care about the residents and have got to know people really well, we know people's ways and how they prefer things.

People seem happy. It's like a family here." A relative told us, "All the staff are marvellous and my relation responds to them very well." Relatives told us that there were no restrictions on visiting people. One relative said, "Staff are very welcoming." Another relative said, "We are always made to feel very welcome."

People's preference for male or female care workers was noted in their initial assessments and care plans. Staff members were aware of people's choices. One relative told us " When my relation said they would prefer a female carer it was agreed straightaway and their view was respected." Work was allocated to staff members who reflected people's preferences, this meant that people's right to choose male or female care workers was respected and this also protected people's sexual, religious or cultural needs.

Throughout the inspection we saw many examples of the caring approach of staff members. One person who was living with dementia showed signs of being confused and became upset. A staff member noticed and took immediate action to reassure the person, using a gentle approach. They knelt beside the person and engaged them in conversation which seemed to reassure them. People appeared comfortable with the staff and one person told us, "They know me very well, they understand me."

People were supported to express their views about their care and support and their wishes were captured within care plans. Where people needed help or support to communicate their wishes family members had been consulted. Information was available about how to access advocacy services for people who needed support. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Some people had difficulty in communicating their needs and views. The registered manager was aware of their responsibilities to remove barriers to communication in line with the requirements of accessible communication standards. Communication care plans guided staff in how to ensure that people were supported effectively. For example, a communication file, containing relevant photographs, was being used to support one person to be actively involved in making choices.

Good

Is the service responsive?

Our findings

At the last inspection on 11 April 2017 we found that the service was not consistently responsive because care plans were not always reflective of the current situation for people. This meant that people were at risk of receiving care that was not appropriate for their current needs. We judged this to be an area of practice that needed to improve. At this inspection on 8 May 2018 we found that improvements had been made and care plans were regularly updated and reflected changes in people's needs.

Care records showed that people, and where appropriate their relatives, were involved in developing care plans based upon assessments of their needs and preferences. Care plans were detailed and person centred. They reflected the physical and mental health needs of people as well as their emotional, spiritual and social needs. Care plans focussed on the individual needs and wishes of people. Descriptive sentences were used to help make it clear to staff how people wished to be supported. For example, care plans routinely included sentences starting with, 'I would like…; I am unable…; I am able…; I need assistance to…

A staff member told us that care plans were updated as part of the □resident of the day□ initiative. This involved reviewing all aspects of the person's care with them, and if appropriate with their relative, to ensure that details were up to date and remained accurate. One staff member said, "When we have resident of the day we try and make it a special day for the person where the focus is really on them." A key worker system was in place. This enabled people to have a named member of staff to take a lead and special interest in their care and support. The registered manager said that the key worker role included ensuring that the person had all the things they needed and identifying anything that might make life more comfortable or interesting for them.

Staff gave us examples of how they had provided support to meet the diverse needs of people using the service, including those related to disability, gender, ethnicity, faith and sexual orientation. These needs were recorded in care plans and staff we spoke with knew the needs of each person well. For example, some people had particular religious beliefs and staff were aware of certain specific needs associated with their faith.

Details about people's background and personal history were included within their care records. Staff told us that this helped them to provide care in a personalised way. For some people English was not their first language. Staff had developed a system for communicating with one person in their native language using key phrases on a communication board to support the person. The person's ethnicity was evident throughout their care plan and staff knew the importance of significant events in the person's life. Staff told us they used this information to help the person to feel settled and comfortable, for example, the person enjoyed listening to traditional music from their native country.

People and their relatives told us that staff noticed changes in people's needs. We noted that care records were regularly reviewed and updated to reflect changes. This ensured that staff had the information they needed to provide care that was appropriate. For example, a person was living with diabetes and their care

plan indicated actions to take if their blood sugar readings were outside a specific range. Monitoring was regularly recorded and staff had taken appropriate actions and followed the advice given by the diabetic nurse specialist.

People's need for social interaction and stimulation had been assessed and care plans included details of their personal preferences, interests and the people and things that were important to them. The home had an activities co-ordinator who arranged a variety of events on a regular basis. People told us they enjoyed the activities on offer. One person said, "They have entertainers and the activity girl is very good. They bring me my newspaper every day." The activities co-ordinator explained how activities were planned to include people's interests. They used their knowledge of people to develop group and individual activities and explained how changes were made following feedback from people. For example, an afternoon activity had been enjoyed but one person had been very sleepy throughout. The activity co-ordinator had recognised this and planned a similar event in the morning next time.

Throughout the inspection we saw that people were occupied and had things to do that were meaningful for them. For example, some people were reading, completing puzzles and word games. Others were watching television or listening to music in their rooms. We heard staff offering to support people to go out into the garden and observed some people engaging in a game in the lounge. People appeared to be enjoying themselves with lots of laughter and cheering each other on. The atmosphere was comfortable and relaxed.

Some people were identified as being at risk of social isolation. We noted that staff were regularly checking people and spent time chatting to them when they did so. The activities co-ordinator explained that they regularly spent time with people in their rooms and described some of the activities that people enjoyed. For example, they told us about one person saying, "They love a piece of chocolate and a chat while someone massages their hands with cream."

Some people were living with dementia and specific items of interest were available for them to pick up. For example, one person found it soothing to stroke a therapy cat (soft robotic cat). Attention was paid to people's sensory needs so activity plans included details of how people liked to spend their day, according to what they liked to hear, see, taste and smell.

People were supported to maintain contact with people who were important to them. For example, staff supported one person with an electronic tablet to connect with their family, using internet based communication with a camera. Another person had regular visits from members of their church, to support them with their spiritual needs.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. The registered manager had ensured that people's communication needs were highlighted within their care plans, using a colour coding system. This information was also included within staff handover documents, to enable staff to easily identify people who had communication needs, due to sensory loss or disabilities. Staff said that this helped them to brief visiting professionals about people's individual communication needs, to enable a more personalised approach.

People told us that they knew how to complain and would feel comfortable to raise any concerns. One person said, "I would tell the manager if I wasn't happy." A relative told us about a complaint they had raised and said, "It was addressed and things have improved now." The provider's complaints policy was on

display in the hallway at the entrance to the home. Complaints forms were available in people's rooms and feedback forms were also available. Records showed that complaints were dealt with in a timely way and people's concerns had been addressed. The registered manager described using information from complaints to help make improvements at the home.

People were being supported to plan for end of life care. Some people had advanced care plans in place detailing their wishes. Where appropriate, people's relatives had been included in making plans. Records showed that people's wishes were clearly recorded and included consideration of their ethnic, religious or spiritual needs. A staff member told us about a person who had requested that their partner be with them at the end of their life. Staff had supported the person's partner to participate in providing care to the person, in line with both people's wishes.

Good

Is the service well-led?

Our findings

At the last inspection on 11 April 2017 we found that the service was not consistently well-led because although improvements in the quality of the service were seen, they were not yet fully implemented and sustained. We identified this as an area of practice that needed to improve. At this inspection on 8 May 2018, we found that improvements had continued and were now fully embedded and sustained within staff practice.

At the time of the inspection the manager had applied to be the registered manager. Following the inspection it was confirmed that they had successfully completed the application process. People and their relatives spoke highly of the registered manager and described them as being easy to talk to, approachable and efficient. One person said, "If I go to the manager it gets dealt with." Another person said, " I find the manager very approachable, we tell her our concerns and they are addressed very quickly." A relative told us, "I would talk to the manager if I wasn't happy about something and then it would get sorted."

Staff also spoke highly of the management at the home. One staff member said, "The registered manager treats the staff well and that includes agency staff. It is a good place to work and I am 100% happy here." Another staff member said," I've been well supported, I love my job." Staff reported high levels of job satisfaction and said they felt valued in their roles.

Leadership was visible and staff were clear about their roles and responsibilities. The registered manager spent time working alongside staff and said this was important in understanding risks and assessing staff practice. Staff spoke positively about the open nature of the home and said they felt their views were welcomed and ideas were taken seriously. Notes from staff meetings showed that staff were able to express their opinions and discuss practice in a positive way.

There was a strong emphasis on providing a comfortable and homely environment for people living at the home. One relative described Downlands as being, "Small and friendly, a really homely place." People and relatives told us they were included in decisions about the home and notes from meetings confirmed that people were encouraged to express their views.

Quality assurance systems and processes were consistently used to identify shortfalls and drive improvement. For example, feedback on standards of care was gathered in a variety of ways, including through the complaints process, during individual reviews, resident and relatives' meetings and with a questionnaire. A suggestions box was also situated near the entrance to the home. The registered manager used a number of audit tools to monitor quality and had oversight of incidents and accidents to analyse and determine any patterns. Action plans showed how improvements were made and identified timescales for implementation of changes.

Staff described positive working relationships within the home and with other agencies. Communication systems were effective in passing information between staff. Agency workers also reported being included, for example in handover meetings. Staff had made links within the local community and described benefits

that had resulted from this. For example, work with the Care Home In-Reach Team (CHIRT) had led to consideration of good practice in a number of areas. This included supporting people with night-time routines with the aim of reducing their reliance on medication.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment. They were also aware of changes made in November 2017 to the key lines of enquiry that CQC use to assess how providers are meeting the Regulations.