Olea Care Ltd

Fernlea

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 was an unannounced inspection that took place on 28 September 2016. This was the first inspection since the service was registered in October 2014. There were 46 people using the service at the time of the inspection.

Fernlea is a purpose built two storey detached home situated in the residential area of Hazel Grove Village, close to public transport and local facilities. The home is set in well-maintained gardens with adequate parking and clearly defined parking areas for disabled visitors. Fernlea is registered to provide accommodation for up to 50 adults who require nursing or personal care.

The home had a manager registered with the Care Quality Commission (CQC) who was present on the day of the inspection. 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.

We found that suitable arrangements were in place to help safeguard people from abuse. Staff knew what to do if an allegation of abuse was made to them or if they suspected that abuse had occurred. Staff were able to demonstrate their understanding of the whistle blowing procedures (the reporting of unsafe and/or poor practice).

We found people were cared for by sufficient numbers of suitably skilled and experienced staff who were safely recruited. Staff received the essential training and support necessary to enable them to do their job effectively and care for people safely.

We saw people looked well cared for and there was enough equipment available to ensure people's safety, comfort and independence were protected. People's care records contained enough information to guide staff on the care and support required. The records showed that risks to people's health and well-being had been identified and plans were in place to help reduce or eliminate the risk. We saw that people were involved and consulted about the development of their care plans.

People told us they received the care they needed when they needed it. They told us they considered staff were kind, had a caring attitude and felt they had the right skills and knowledge to care for them safely and properly. We saw that staff treated people with dignity, respect and patience.

Procedures were in place to prevent and control the spread of infection and risk assessments were in place for the safety of the premises. All areas of the home were secure, clean, well maintained and accessible for people with limited mobility; making it a safe environment for people to live and work in.

We saw that appropriate environmental risk assessments had been completed in order to promote the

safety of people who used the service, members of staff and visitors. Systems were in place for carrying out regular health and safety checks and equipment was serviced and maintained regularly. Procedures were in place to deal with any emergency that could affect the provision of care, such as a failure of the electricity and water supply.

The medication system was safe and we saw how the staff worked in cooperation with other healthcare professionals to ensure that people received appropriate care and treatment.

Staff were also able to demonstrate their understanding of the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

People were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We saw that food stocks were good and people were able to choose what they wanted for their meals.

To help ensure that people received safe and effective care, systems were in place to monitor the quality of the service provided. Regular checks were undertaken on all aspects of the running of the home and there were opportunities, such as resident/relative meetings and satisfaction surveys for people to comment on the facilities of the service and the quality of the care 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.

We found that sufficient numbers of staff were provided to meet the needs of the people who used the service. A safe system of staff recruitment was in place and suitable arrangements were in place to help safeguard people from abuse.

The system for the management of medicines was safe. The care records showed that risks to people's health and well-being had been identified and plans were in place to help reduce or eliminate the risk.

All areas of the home were clean and well maintained and procedures were in place to prevent and control the spread of infection.

Is the service effective?

Good

The service was effective.

Staff received training to allow them to do their jobs effectively and safely and systems were in place to ensure staff received regular support and supervision.

We found the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met.

The layout of the building ensured that all areas of the home were accessible for people whose mobility was limited.

Is the service caring?

Good

The service was caring.

People spoke positively of the kindness and caring attitude of the staff. We saw that staff treated people with dignity, respect and

patience.

The staff showed they had a very good understanding of the needs of the people they were looking after.

Specialised training was provided to help ensure that staff were able to care for people who were very ill and needed end of life care.

Is the service responsive?

Good

The service was responsive.

The care records contained sufficient information to guide staff on the care to be provided. The records were reviewed regularly to ensure the information contained within them was fully reflective of the person's current support needs.

Suitable arrangements were in place for reporting and responding to any complaints or concerns.

Is the service well-led?

Good

The service was well–led.

The home had a manager registered with the Care Quality Commission.

Systems were in place to assess and monitor the quality of the service provided and arrangements were in place to seek feedback from people who used the service.

The registered manager had notified the CQC, as required by legislation, of any incidents that had occurred at the home.

Fernlea

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 28 September 2016 and was unannounced. The inspection team consisted on two adult social care inspectors.

Prior to our inspection of the service we were provided with a copy of a completed provider information return (PIR); this is a document that asked the provider to give us some key information about the service, what the service does well and any improvements they are planning to make. Before our inspection we looked at notifications that were sent to us by the registered manager to inform us of any incidents and significant events.

Following the inspection we contacted some of the healthcare professionals who provided funding for the care of some of the people who use the service. At the time of writing this report they had not replied.

During the inspection we spoke with five people who used the service, two relatives, the registered manager, the operations manager, three care staff, the chef and two domestic staff.

We looked around all areas of the home, looked at how staff cared for and supported people, looked at food provision, six people's care records, the medicine management system, four staff recruitment and training records and records about the management of the home.

Good

Is the service safe?

Our findings

Comments made demonstrated to us that people felt safe. Their comments included; "They [staff] make you feel very comfortable and very safe" and "I love it here. I am very safe and very lucky".

Policies and procedures for safeguarding people from harm were in place. These provided staff with guidance on identifying and responding to signs and allegations of abuse. In addition, we saw 'easy read' documents displayed throughout the home to help people who used the service know who to speak with if they did not feel safe. The training records we looked at showed that all staff had received training in the protection of vulnerable adults. Staff we spoke with were able to tell us what action they would take if abuse was suspected or witnessed.

We saw the home had a whistleblowing policy. This told staff how they would be supported if they reported poor practice or other issues of concern. Staff we spoke with were familiar with the policy and knew how to escalate concerns within the service. They also knew they could contact people outside the service if they felt their concerns would not be listened to.

The care records we looked at showed that risks to people's health and well-being had been identified, such as poor nutrition, choking and the risk of developing pressure ulcers. We saw care plans had been put into place to help reduce or eliminate the identified risks.

We looked around all areas of the home. To gain access to the home people had to ring the door bell and wait to be allowed access. This helped to keep people safe by ensuring the risk of entry into the home by unauthorised persons was reduced. The bedrooms, dining room, lounges and corridors were well lit, clean and bright and there were no unpleasant odours. The wide corridors and handrails helped to ensure safe movement around the home.

Records showed risk assessments were in place for all areas of the home environment. The records also showed that the equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This helps to ensure the safety and well-being of everybody living, working and visiting the home. The provider had taken steps to ensure the safety of people who used the service by ensuring the windows were fitted with restrictors and the radiators were suitably protected with covers.

We looked to see what systems were in place in the event of an emergency. We saw personal emergency evacuation plans (PEEPs) had been developed for all the people who used the service. These were kept in people's individual care files and also in a central file to ensure they were easily accessible in the event of an emergency. We also saw the procedures that were in place for dealing with any emergencies that could arise, such as utility failures and other emergencies that could affect the provision of care.

We found that regular fire safety checks were carried out on fire alarms, emergency lighting, smoke detectors and fire extinguishers. We saw fire risk assessments were in place and records showed that staff had received training in fire safety awareness.

We saw that procedures were in place for dealing with accidents and incidents. These guided staff on what to do, who to tell and how and where incidents were to be recorded. Records we looked at showed that accidents and incidents had been recorded and the registered manager reviewed them regularly. Monitoring accidents and incidents can assist management to recognise any recurring themes and then take appropriate action; helping to ensure people are kept safe.

We looked at the on-site laundry facilities. The laundry looked clean and well-organised. Hand-washing facilities and protective clothing of gloves and aprons were in place. We found there was sufficient laundry staff and sufficient equipment to ensure safe and effective laundering. The washing machines had a sluicing facility to wash soiled linen.

We saw infection prevention and control policies and procedures were in place, regular infection control audits were undertaken and infection prevention and control training was an essential part of the training programme for all staff. We were told there was a designated lead person who was responsible for the infection prevention and control management. We saw staff wore protective clothing of disposable gloves and aprons when carrying out personal care duties. Alcohol hand-gels and hand-wash sinks with liquid soap and paper towels were available throughout the home. Good hand hygiene helps prevent the spread of infection. We saw that appropriate arrangements were in place for the safe handling, storage and disposal of clinical waste.

We spoke with two of the domestic staff who told us they had received training in infection control and the control of substances harmful to health (COSH).They told us they had access to appropriate cleaning equipment and materials and personal protective equipment such as gloves and aprons. We were shown the cleaning schedules that were in place for each area of the home. They outlined the daily, weekly and monthly duties for cleaning the environment, equipment and furniture.

One person who used the service told us, "It's spotless. They are always cleaning".

Inspection of the staff rosters, discussions with people who used the service, relatives and staff showed there were sufficient suitably qualified and competent staff available at all times to meet people's needs. One comment made to us was, "I feel there are enough staff around. The staff respond quickly. If I ring my bell at night they always come".

The registered manager told us they were in the process of recruiting for registered nurses but as an interim measure agency registered nurses were provided where necessary. We were told the agency sent the same registered nurses whenever possible to ensure people who used the service received care from people who were familiar with their needs.

We asked management to tell us how they ensured their staff recruitment procedure protected the health and safety of people who used the service and that the people they employed were fit to do their job. We were shown the recruitment policy and procedure that was in place. It gave clear guidance on how staff were to be properly and safely recruited. We did have a discussion with the registered manager about the possibility of developing their interview questions and notes further to show how staff had demonstrated their knowledge and skills; helping to ensure that only people with the correct qualifications, skills and experience were employed. The registered manager agreed this was good practice and told us they intended to amend the interview documentation.

We looked at four staff recruitment files .The staff files contained proof of identity, application forms that documented a full employment history, a medical questionnaire, a job description and, for three of the files,

at least two professional references. We did note however that for one person there was no evidence that two out of the three written references requested had been received. It was documented that verbal references had been given. We were told that despite a repeated request from the service, the written references had not been received. Following a discussion with the registered manager it was agreed that it would be good practice to show written evidence of further requests being made. This would demonstrate that management had taken all reasonable steps to obtain written references to ensure the fitness of people employed by the service.

Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. The registered provider had checked that the registered nurses who worked at the service had a current registration with the Nursing and Midwifery Council (NMC). We saw that a profile of each agency nurse and care staff member was obtained by the service from the supplying agency. These further checks helped to ensure that people who used the service were cared for by staff that had been suitable recruited by the agency.

We looked to see how the medicines were managed. We found the systems for the receipt, storage (including controlled drugs), administration and disposal of medicines were safe. There was a detailed medicine management policy and procedure in place. In addition the service had the Nursing and Midwifery Council standards, The National Institute for Clinical Excellence (NICE) and the Royal Pharmaceutical Council guidelines in place in relation to medicine management.

We found that medicines, including controlled drugs, were stored securely. The medicines in current use were kept in locked medicine trolleys in a locked room. We were told the medicine keys were always kept with the nurse and the senior care assistant responsible for the management of medicines. Having authorised access to medicines helps to prevent them from being misused.

Appropriate arrangements were in place to order new medicines and to safely dispose of medicines that were no longer needed. Although medicines no longer needed were kept secure in a container that was kept in a locked cupboard in a locked room the container was not tamper-proof. We discussed this with the registered manager who told us they would contact the dispensing pharmacy or the clinical waste company to obtain one.

We checked the medicine administration records (MARs) of five people who used the service. The records showed that people were given their medicines as prescribed, ensuring their health and well-being were protected.

It was identified from the MARs that some medicines were to be given 'when required' or as a 'variable dose' of one or two tablets. We saw that information was available in each person's care plan to guide staff when they had to administer medicines that had been prescribed in this way. We discussed with the registered manager the possibility of also providing guidance with the person's MAR. This would ensure that the information was readily available for all staff, including agency registered nurses, when they were administering the medicines. The registered manager agreed that this would be beneficial and told us the guidance would be included alongside the MAR.

We saw that several people were prescribed 'thickeners'. Thickeners' are added to drinks, and sometimes food, for people who have difficulty swallowing, and they may help prevent choking. A discussion with staff showed they knew when the thickeners were to be given and how much was required for each person. We saw that staff followed the speech and language therapists written instructions that made statements such

as, 'runny honey' and 'porridge'. We discussed with the registered manager the possibility of ensuring that the written instructions for staff were more specific such as how many scoops of the thickener to be added to the amount of fluid. The registered manager agreed that this would be a much safer way of ensuring the thickeners were mixed to the correct consistency.

We saw that although the MARs showed that the staff responsible for administering medicines recorded when the thickeners had been given, the recordings were not always accurate. This was because on many occasions it was the care staff who administered the thickened fluids. The registered manager told us they would ensure accurate recording by providing charts for the care staff to record when they had given the prescribed thickeners. We were shown the charts they would use.

Good

Is the service effective?

Our findings

People we spoke with told us they received the care they needed when they needed it. They told us they considered staff had the right attitude, skills and knowledge to care for them safely and properly. Comments made included; "I can't fault them. I am well looked after" and "From my view we are very well looked after".

We looked to see how staff were supported to develop their knowledge and skills. We were shown the induction programme that newly appointed staff had to undertake on commencement of their employment. Induction programmes help staff understand what is expected of them and what needs to be done to ensure the safety of the people who use the service, staff and visitors. The registered manager told us that induction took up to 12 weeks and that staff were fully supervised until their competency to undertake their role had been assessed. Staff we spoke with confirmed that this information was correct. We did note that the induction records were not always 'signed off' by a senior staff member when they had been completed. We informed the registered manager of this who told us this would be addressed straightaway.

We were shown the handbook that was given to staff when they started to work at the home. The handbook included information about confidentiality, expected standards of conduct, training and terms and conditions of employment. It also contained policies and procedures to guide staff on the company's expectation about sickness, absence and the disciplinary and grievance procedures.

We were also shown the training plan that was in place for all the staff. It showed staff had received the essential training necessary to safely care and support people who used the service.The records we looked at confirmed staff had also received training relevant to their role such as; urinary catheterisation, end of life care, nutrition and dysphagia (swallowing difficulties). Staff confirmed their training was well organised and that the provider responded favourably to requests for additional specialist training.

A discussion with the staff showed they had a good understanding of the needs of the people they were looking after. Staff told us they received a verbal and written report on each shift change. This was to ensure that any change in a person's condition and subsequent alterations to their care plan was properly communicated and understood.

The records we looked at showed systems were in place to ensure staff received regular supervision and appraisal. Supervision meetings help staff to discuss their progress and any learning and development needs they may have and also raise good practice ideas. The three care staff we spoke with told us they had regular supervision sessions with the operations manager.

From our discussions with people, our observations and a review of people's care records we saw that people were consulted with and, if able, consented to their care and support. We saw how staff requested people's consent before attending to their needs. The registered manager told us that if people were not able to consent then a 'best interest' meeting would be held on their behalf. A 'best interest' meeting is

where other professionals, and family where relevant, decide on the course of action to take to ensure the best outcome for the person using the service.

We asked the registered manager to tell us what they understood about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The 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, hospices and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

What the registered manager told us demonstrated they had a good understanding of the MCA and DoLS and knew the procedures to follow if an authorisation was required. The Care Quality Commission is required by law to monitor the operation of the DoLS and to report on what we find. We were told that four people who used the service were subject to a DoLS. The registered manager told us they had received training in the MCA and DoLS and were in the process of arranging training for the rest of the staff.

We checked to see if people were provided with a choice of suitable and nutritious food to ensure their health care needs were met. Picture menus were displayed in the dining room. They showed the choice of meals available both for lunch and the evening meal. They also showed the lighter snacks that were available if people did not want any of the choices on offer. People who used the service spoke positively about the quality and variety of the meals and drinks. Comments made included; "The food is lovely and there is plenty of choice. If you don't like it they won't give it to you. You can always have something else" and "I like the theme nights because I enjoy trying different sorts of food from other countries".

We looked at the kitchen and food storage areas and saw good stocks of fresh, frozen and dry foods were available. We saw a fruit platter in one of the fridges and were told that fresh fruit was always made available and that the platter was routinely taken out on the 'drinks trolley'. We spoke with the chef who showed us a file that contained the dietary requirements and special diets of each person who used the service. We were told none of the people who used the service observed any religious or cultural dietary laws. The chef told us that a cooked breakfast was offered and that food was always available out of hours. A discussion with the chef showed they were aware of how to fortify foods to improve a person's nutrition.

People who used the service told us they could take their meals in the dining room or in their own room. We saw some people sitting in the dining room shortly after finishing their breakfast. They looked very relaxed; some finishing their tea or coffee and one person reading their newspaper. The dining room was very tastefully decorated and furnished; the doors leading out onto an enclosed courtyard where people could be served drinks if they wished. The dining tables were nicely set with tablecloths, napkins and condiments. Leading off from the dining room was the area known as the Coffee Bistro Bar. Here people could sit and have hot snacks and drinks, served from the adjacent well- stocked servery.

The care records we looked at showed that people had an eating and drinking care plan and were assessed in relation to the risk of inadequate nutrition and hydration. Records we looked at showed that following each meal staff completed records for the people who required monitoring of their food and fluid intake. We saw action was taken, such as a referral to the dietician or to their GP, if a risk was identified. The care records also showed that people had access to external healthcare professionals, such as tissue viability nurses, opticians and dentists.

The layout of the building ensured that all areas of the home were accessible for people whose mobility was limited. Bedroom accommodation was provided on the ground and first floor and access to the first floor was via a passenger lift. All the rooms on the ground floor gave direct access to the gardens that had plenty of garden furniture in place. Adequate equipment and adaptations were available to promote people's safety, independence and comfort. Each person had a special type of bed that helped staff position them more easily and had a pressure relieving mattress in place to promote comfort and help prevent pressure ulcers developing.

We saw that bathrooms and toilets had aids and adaptations in place and had been planned to increase accessibility and promote people's independence, safety and comfort. Grab rails and toilet seats were colour coded to aid with visibility and recognition. Ceiling tracking was in place in some of the bathrooms and in 14 of the bedrooms to enable staff to safely hoist and transfer people whose mobility was greatly impaired. The car parking areas were well laid out with very clear signage and clearly defined parking areas for disabled visitors.

Good

Is the service caring?

Our findings

We received positive comments about the kindness and attitude of the staff. Comments made included; "The staff are marvellous and you can have a laugh with them", "I have no complaints about anything", "I can't grumble about anything, it's not like home but I'm happy enough and "The staff have a lovely attitude".

People looked well cared for, were clean, appropriately dressed and well groomed. One person told us they liked to wear their make-up, perfume and jewellery every day and that staff always ensured their wishes were met. We observed staff spoke quietly and treated people with kindness and respect. The atmosphere in the home was cheerful, calm and relaxed. We saw that staff knocked and waited for an answer before entering bathrooms, toilets and people's bedrooms. This was to ensure people had their privacy and dignity respected.

We were informed that the home had received the Dignity in Care accreditation award. Dignity in care work focuses on the value of every person as an individual. It means respecting others' views, choices and decisions, not making assumptions about how people want to be treated and working with care and compassion.

We found the environment had been organised in a way that promoted people's privacy, dignity and confidentiality. Each person had their own room with the facility of an en-suite shower and toilet. All the rooms were wired for private telephone lines and Sky TV. The four large lounges, the smaller sitting areas and the Coffee Bar Bistro enabled people to choose where they wished to spend their time, either alone or with visitors.

We found the service had placed great importance on ensuring that people's bathing experience was not just a task but was something that was pleasurable and relaxing. The home had hydro-spa and aroma-spa bathing facilities that could offer people either a water jet underwater muscle massage or aromatic bathing with essential oils.

Staff told us that people's religious and cultural needs were always respected and that people could choose to have their own clergy visit them. We were told the Church of England clergy routinely visited the home once a month.

A discussion with the registered manager showed they were aware of how to access advocates for people who had nobody to act on their behalf. An advocate is a person who represents people independently of any government body. They are able to assist people in many ways; such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them.

We asked the registered manager to tell us how staff cared for people who were very ill and at the end of their life. We were told that some of the staff had successfully completed the Six Steps end of life training and others were about to undertake it. The Six Steps programme guarantees that every possible resource is

made available to facilitate a private, comfortable, dignified and pain free death. We were also informed that the staff at the home received good support from the community nurses and the local GPs.

Staff we spoke with were aware of their responsibility to ensure information about people who used the service was treated confidentially. We saw that care records were kept secure in the staff office. This was to ensure information about people was accessible to staff but kept confidential.

Good

Is the service responsive?

Our findings

People told us that staff responded well to their needs. Comments made included; "I think [relative] is looked after so well and the staff are marvellous" and "They know what I need and make sure I get it".

The six care records we looked at showed that detailed assessments were undertaken prior to the person being admitted to the home. This was to ensure their identified needs could be met. The care records showed that information gathered during the assessment was used to develop the person's care plan.

We saw there were two sets of care plans for each person. We were told that management were in the process of updating the care planning system and that was the reason people had two files. We were told information that was not current was kept in one file and relevant up to date information was kept in another. Our inspection of the care files showed this was not always what happened. We found that although the relevant information was in place, it was difficult at times to find it in the file we were directed to. The registered manager told us it was 'work in progress' and would be dealt with to ensure the relevant information was in the correct file and accessible to all staff.

The care records contained enough information to show how people were to be supported and cared for. The information in the care records showed that people had been involved in the planning of their care They contained details of people's preferences around care and support, plus their likes and dislikes. The care records also contained risk assessments. These were in relation to assessing risks if people had problems with certain aspects of their health, such as a history of falls, a need for support with moving and handling, poor nutrition or a risk of choking. We saw that the care records were reviewed regularly by staff to ensure the information was fully reflective of the person's current support needs.

It was noted that some of the information in the care records was not always dated. To ensure that information contained in the records is up to date, and therefore relevant, they must be dated. The registered manager addressed this matter whist we were present.

People told us they had regular access to other health care professionals such as their GP, dentists and chiropodists. One person told us how they were receiving treatment from a physiotherapist to help improve their mobility and independence. The registered manager told us that every Monday a GP from the local practice undertook a full morning visit. The registered manager told us the staff at the home and the GPs found this very useful as it ensured regular monitoring of people's health and helped to reduce the number of GP visits to the home.

We asked the registered manager to tell us how, in the event of a person being transferred to hospital or another service, information about the person was relayed to the receiving service. We were told that in addition to a copy of their MAR sheet, a copy of their care documents and a written summary of their needs would accompany them. This helps to ensure continuity of care.

The registered manager told us that an activities organiser was employed by the home but was on long-

term leave. We were told that, in the interim, activities were provided by other members of staff and also by outside entertainers. People we spoke with were aware that the designated activities organiser was not available but told us they still enjoyed the activities provided. Activities included such things as; film shows, board games, quizzes, musical movement, shopping trips, pamper sessions and the gardening club. We were told about the forthcoming events planned for the Christmas celebrations. People told us they were looking forward to Christmas in the home. One person told us about their recent birthday party that was held at the home. They told us they were given the use of one of the small lounges to host their party and that they had a wonderful time surrounded by their family.

We saw people were provided with clear information about the procedure in place for handling complaints. A copy of the complaints procedure was displayed on notice boards in the corridors. The procedure explained to people how to complain, who to complain to, and the times it would take for a response. The people we spoke with told us they had no concerns about the service they received and were confident they could speak to the staff if they had any concerns. We saw that the registered provider kept a log of any complaints made and the action taken to remedy the issues.

Good

Is the service well-led?

Our findings

The service had a registered manager who was present on the day of the inspection. A discussion with the registered manager showed they were clear about their aims and objectives for the service. This was to ensure the service was run in a way that supported the need for people to gain independence through the most effective high quality care possible, be involved in decision making and respect their right to take informed risks.

We asked the registered manager to tell us what systems were in place to monitor the quality of the service to ensure people received safe and effective care. We were shown the quality assurance system that was in place. This showed that regular checks were undertaken on all aspects of the running of the home such as; infection control, the environment, medication, dignity issues and care plans. We saw that where improvements were needed action was identified, along with a timescale for completion.

We asked the registered manager to tell us how they sought feedback from people who used the service to enable them to comment on the service and facilities provided. We were told that satisfaction surveys were given out to people, usually every three months. We looked at the 10 responses to the satisfaction surveys from July 2016. They were all very positive about people's experiences and the care they received. We were also told that people and their visitors were free to speak with the registered manager and staff at any time. A relative we spoke with confirmed this information was correct.

We were also told that regular resident and relatives meetings were held. We looked at the records from the residents' meetings that had been held in May 2016 and August 2016. Topics of discussion at the meetings included such things as; activities, meals, staffing levels, involvement in care plan reviews and the laundry service.

Records showed that staff meetings were held regularly, at least every three months. Staff meetings are a valuable means of motivating staff, keeping them informed of any developments within the service and giving them an opportunity to discuss good practice. Staff confirmed to us that regular staff meetings were held and staff told us they felt included and consulted with. Staff spoke positively about working at the home They told us they felt valued and that management were very supportive. Comments made included; "Management are there all the time and I feel we are a really good team as we all gel together" and "I love it here and enjoy coming to work".

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.