Enhanced Elderly Care Limited

Enhanced Elderly Care Service - Fellingate Care Centre Limited

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 which we carried out on 7 December 2016.

We last inspected Enhanced Elderly Care Services Fellingate Care Centre in August 2015. At that inspection we found the service was not meeting all of the legal requirements in force at the time.

Enhanced Elderly Care Services Fellingate is a purpose built care home that provides personal and nursing care to a maximum of 81 older people, including people who live with dementia. At the time of inspection 74 people were living at the home.

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

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff were aware of the whistle blowing procedure which was in place to report concerns and poor practice. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received. Other people could tell us they felt safe. People appeared contented and relaxed with the staff who supported them. People and relatives said staff were kind and caring. Staff had more time to interact and engage with people and not just when they carried out tasks.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff received opportunities for training to meet peoples' care needs and in a safe way. A system was in place for staff to receive supervision and appraisal and there were robust recruitment processes being used when staff were employed.

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were able to make choices where they were able about aspects of their daily lives. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines in a safe and timely way.

Staff supported people who required help to eat and drink and special diets were catered for. Some activities and entertainment were available for people and people were being consulted to increase the variety of activities and outings.

A complaints procedure was available. People told us they felt confident to speak to staff about any concerns if they needed to. Staff and people who used the service said the registered manager was supportive and approachable. People had the opportunity to give their views about the service. Feedback was acted upon in order to ensure improvements were made to the service when required. The provider undertook a range of audits to check on the quality of care provided. Records had been updated and they were regularly reviewed to reflect peoples' care and support requirements.

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.

People were kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm. Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Regular checks were carried out to ensure the building was safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals. Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were kind and patient.

Staff spent time with people and interacted and engaged with them not just when they provided support. People were encouraged and supported to be involved in daily decision making.

Staff were aware of people's backgrounds and personalities. This helped staff provide individualised care to the person. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

Is the service responsive?

Good

Improvements had been made to ensure the service was responsive.

Improvements had been made to record keeping. This meant people received support in the way they wanted and needed because staff had detailed guidance about how to deliver their care.

People were provided with some activities and entertainment.

People had information to help them complain. Complaints were investigated and any action taken was recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff told us the manager team were supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was
good.

The home had a quality assurance programme to check on the quality of care provided.

Enhanced Elderly Care Service - Fellingate Care Centre Limited

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 7 December 2016 and was unannounced. The inspection team consisted of one adult social care inspector and one 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 for older people.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with eight people who lived at Fellingate Care Centre and six relatives. We

also spoke to the registered manager, the provider's nominated representative, the deputy manager, one registered nurse, eight support workers, the activities coordinator, one domestic, one member of catering staff and a visiting care professional. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for eight people, recruitment, training and induction records for five staff, six people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. People's comments included, "Staff are around when I need them" and "I feel safe with staff looking after me."

We considered staffing levels were sufficient to provide safe and individual care to people. The registered manager told us staffing levels were determined by a dependency tool. This was used to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely. At the time of inspection there were 74 people who were living at the home supported by two nurses and 14 support workers, including three senior support workers. Staffing rosters and observations showed on the ground floor 23 people were supported by two registered nurses and four support workers. On the middle floor 24 people were supported by one senior support worker and four support workers. The top floor accommodated 27 people supported by five support workers including two senior support workers. Overnight staffing levels included from 8:00pm until 8:00am one nurse and seven support workers, including two senior support workers. These numbers did not include two additional support workers who also worked from 6:00pm -11:00pm to assist in the evening.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the registered manager. Since 2015 four safeguarding alerts had been raised outside of the service. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team.

Staff had receiving training about safeguarding, they had an understanding of safeguarding and knew how to report any concerns. One staff member told us, "I've done safeguarding training with the local authority." Staff were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse. They told us they would report any concerns to the registered manager or the nurse in charge. Staff were aware of the lines of reporting within the organisation. They were aware of the provider's whistle blowing procedure and knew how to report any worries they had. The provider's PIR stated, 'Safeguarding and whistleblowing are discussed at every staff supervision as a standard agenda item.'

People received their medicines in a safe way. Up-to-date policies and procedures were in place to support staff and to ensure medicines were managed in accordance with current guidance. People had 'medicine capacity' assessments in place to record the support they required when their medicines were administered. We observed a medicines round and saw the worker remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. We found that there were no gaps in signatures and all medicines were signed for after administration. All medicines were appropriately stored and secured.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for spilling drinks, falls, skin integrity and nutrition.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plans were reviewed monthly to ensure they were up to date. These were used in the event of the building needing to be evacuated in an emergency.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. Copies of interview questions and notes were also available to show how each staff member had been appointed.

Records showed that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. Staff comments included, "We get loads of training", "There are training opportunities all the time", "There's training every other week", "Training is face to face" , "I've had more training than in my other job", "We get training throughout the year" and "You just need to say what training you want to do and they find it."

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. The provider's PIR stated the induction programme was 'being reviewed' and the registered manager had introduced the Care Certificate as part of induction. This was being implemented for new staff and existing staff also had the opportunity to obtain the certificate. A staff member commented, "I'm doing the Care Certificate."

The staff training record showed staff were kept up-to-date with safe working practices. The registered manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included distressed behaviour, nutrition and malnutrition, continence care, wound management, pressure area care, privacy and dignity awareness, person centred care, falls awareness, equality and diversity and management training to carry out supervisions and appraisals. Future training included palliative care. The provider's PIR stated 46 support staff had achieved a National Vocational Qualification (NVQ), at level two, now known as the Diploma in Health and Social Care.

Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the registered manager. We were told heads of department were responsible for their department's supervisions. Staff members' comments included, "Seniors supervise support workers", "I'm due a supervision in January" and "We have supervision every two-three months." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs. A staff member commented, "I have an appraisal annually." This showed staff were supported in their role as well as assisted to identify their individual training needs.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

Staff had a good understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. Peoples' care records showed when 'best interest' decisions may need to be made. People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people

who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of and had received training in the MCA and the related DoLS. The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The registered manager told us 52 applications had been authorised and other applications were being processed by the local authority.

People's needs were discussed and communicated at staff handover sessions when all staff changed duty, at the beginning and end of each shift. This was so staff were aware of risks and the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. A staff member told us if there was any change in need identified the person's care plan was updated. Relatives told us they were kept informed by the staff about their family member's health and the care they received. Two relatives commented, "I'm regularly kept up to date with how [Name] is" and "Staff let me know."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as General Practitioners (GPs), district nurses, the behavioural team, psychiatrists and a speech and language team (SALT). We spoke with a visiting health care professional. They told us, "People are appropriately referred." Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals. The home was taking part in a Vanguard model of care initiative as promoted by the government to help reduce the number of hospital admissions. This was apparent with the weekly clinic that took place in the home. The clinic was run by the General Practitioner and specialist nurse for older people. People's relatives were also invited to attend people's appointments to keep them up to date with people's health and well-being. The clinic was held to review people's acute health needs to make sure they were treated promptly.

We checked to see how people's nutritional needs were met. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. People were encouraged to make choices about their food. Menus advertised a choice of two hot meals at meal times. People were positive about the food saying they had enough to eat and received nice food. A food survey for May 2016 showed positive responses about the food. Where people had made any suggestions they were acted upon. For example, some people wanted more herbs in the cooking and better snacks between meals.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Records were in place that recorded people's food likes and dislikes. Examples included, 'Enjoys cheese and crackers as a snack' and 'Likes ice cream.' Care plans detailed the support required to help people eat. For example a nutrition care plan stated, '[Name] can eat independently but staff cut up food into bite size pieces. [Name] likes to eat their food on tray on their lap.'

We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. They told us they received verbal information from nursing staff when people required a specialised diet. We saw a board was available in the kitchen to show information and capture any changes that had been communicated about people's dietary requirements. The cook explained about how people who needed to increase weight would be offered a fortified diet.

Good

Is the service caring?

Our findings

People who could comment were all positive about the care and support provided by staff. Their comments included, "Staff are kind", "It's a great place" and "I couldn't be better looked after." Relatives comments' included, "They (staff) do really good care", "Good care standards for my loved one, as workers on unit for people who live with dementia are excellent", "Care is spot on for [Name]" and "Staff care, they treat [Name] as their own." A visiting professional commented, "The care is good, staff are attentive and listen to people."

We observed the atmosphere was calm, relaxed and tranquil. Throughout the home staff interacted well with people. They were kind and caring and they spent time engaging with people and not only supervising them. Some people had complex needs and we saw staff interacted well with people who we saw were relaxed with them. We saw staff engaged with people in a quiet and compassionate way. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They asked the person's permission before they carried out any intervention. For example, "Can I help you to the table" and "Do you want to have some drink."

Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. They were able to give us information about people's needs and preferences which showed they knew people well. They explained how they involved people in making decisions and supported their opinions on matters such as personal care. Staff described how they supported people who did not express their views verbally. Staff observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. People's care records provided information about how a person communicated. Examples in care plans included, '[Name] does not verbalise their needs, so staff must be aware of signs such as may be tearful or anxious if they need assistance', '[Name] has no issues expressing themselves' and 'Staff to speak clearly, offer clear information and instructions.'

We saw people who lived with dementia were encouraged to make a choice and be involved in decision making. For example, with regard to drinks and other activities of daily living. Staff gave examples of asking families for information and showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. People told us they were offered choices and involved in daily decision making about other aspects of their care. For example, activities and bathing. Care records detailed people's preferences and how they could be enabled to make a choice. Examples included, '[Name] can choose their own outfits' and '[Name] prefers to have a shower.'

We observed the lunch time meals on both floors of the home. The meal time was relaxed and unhurried. At lunch time on the middle floor people who lived with dementia were verbally offered a choice of meal however, they were not shown two plates of food if they were undecided to help them make the choice by smell and visually. We discussed this with registered manager who said it would be addressed with staff. People sat at tables that were set with tablecloths and condiments. Specialist equipment such as cutlery

and coloured dishes were available. Staff remained in the dining areas to provide help and support to people. Some people remained in their bedrooms to eat. Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. For example, "Are you going to eat your pudding." Staff talked to people as they helped them and as lunch was served. They also checked that people had enjoyed their meal.

People's privacy was respected. Staff treated people with dignity and respect. Staff received training to remind them about aspects of dignity in care to promote dignity within the home. We saw staff observed and offered any prompts and words of encouragement to people at meal times to provide assistance. Staff knocked on people's doors before entering their rooms. Most people sat in communal areas but some preferred to stay in their own room. People looked clean and well presented. Care plans provided information for staff about people's preferences for personal care. For example, one care plan stated, '[Name] likes to pick out and choose their own clothing as it encourages [Name] to take a pride in their appearance.'

There was information displayed in the home abut advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. An advocate is an independent worker who can help speak up for people and ensure their rights are promoted.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Good

Is the service responsive?

Our findings

At the last inspection the service was non compliant with regard to record keeping. This was because records did not accurately reflect people's care and support needs for staff to provide the correct care and support in the way the person wanted and needed.

At this inspection we saw that improvements had been made to ensure that records accurately reflected peoples' care and support needs so staff had guidance to provide appropriate care and support. The registered manager also told us a new electronic system for care documents was to be introduced. Care plans would be available on line. This would help to ensure staff had up to date information and guidance about people's care and support needs with more detail of how care was to be delivered and frequency of interventions to make care more person centred.

We were informed arrangements were in place to carry out pre-admission assessments of people to the service. This was to ensure the compatibility of people and to check that staff had the required skills to meet people's needs before they were admitted. There was a good standard of record keeping. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition, communication, mobility and falls and personal hygiene. Evaluations were more detailed and included information about peoples' progress and well-being.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. Care plans were more detailed, provided information and guidance for staff about peoples' care needs and how they liked to be supported and how to maintain some independence. Examples, in care plans for personal care included, "[Name] can wash their top half but require assistance to wash elsewhere' and '[Name] is able to wash themselves but needs some prompting.' Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example, referrals were made to the dietician and speech and language therapist if a person was losing weight or there were concerns about a person's ability to swallow.

Other information was available in people's care records to help staff provide care and support. For example, 'Staff to remind [Name] of the time at night so they will recognise themselves that they should be trying to rest', '[Name] has a risk assessment in place due to spilling drinks' and 'Staff to check pressure areas daily and check for any changes.' Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met.

These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People's care records and personal profiles were up to date and personal to the individual. They contained information about people's history, likes, dislikes and preferred routines. Examples included, '[Name] enjoys listening to Perry Como,' '[Name] prefers coffee to tea and will regularly get themselves a cup with minimal staff assistance' and '[Name] likes to retire to bed around 9:00pm- 9:30pm.'

At the last inspection we had concerns that people who may exhibit behaviour that was described as challenging did not receive consistent care and support because their care plans were not detailed. This inspection showed improvements had been made. Detailed records were in place to provide guidance to staff if a person became distressed. Care plans gave staff instructions with regard to supporting people if they became agitated or distressed. Guidance helped ensure staff worked with the person, to help reduce the anxiety and distressed behaviour. Records were regularly updated to ensure they provided accurate information.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the challenging behaviour team or the department of psychiatry of old age. Staff told us they followed the instructions and guidance of the behavioural team for example to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known. A staff member told us, "We've had training about challenging behaviour. We will try and diffuse the situation."

We were told resident and relative meetings were held three monthly. We saw minutes from a resident meeting held in July 2016. It was a forum for people to be consulted and raise any concerns. Minutes showed some peoples' comments related to more choice of activities, choice of food and healthy eating options and the laundry. People were told their comments would be addressed. People who used the service and relatives told us the registered manager was approachable and they knew they could approach them at any time to discuss any issues. They told us meetings were held regularly and they were generally kept up to date about what was happening in the service. The registered manager told us meetings provided feedback from people about the running of the home.

People said they knew how to complain. A person commented, "I'd speak to the manager if I needed to." The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure in the information pack they received when they moved into the home. A record of complaints was maintained and we saw six had been received and investigated and resolved appropriately. Several cards of appreciation were also available from relatives expressing thanks to staff for the care provided.

A programme of activities was available and two activities organisers were employed to provide activities to people. We received some positive comments about activities but some people and relatives told us they thought more activities were needed. Comments included, "More activities are needed" ,"Staff don't always have time to carry out activities with people" and "I do get fed up sometimes." We discussed this with the registered manager who told us it would be addressed. We were told activities included film afternoons, arts and crafts, bingo, dominoes, pamper sessions, quizzes and a monthly men's club. Forthcoming events and entertainment were advertised and these included coffee mornings and seasonal fayres. We saw a variety of seasonal entertainment was arranged for over the Christmas period including a Christmas party, carol service, Salvation Army choir and entertainers. Staff on the middle floor who provided care to people who

lived with dementia were enthusiastic and keen to share ideas about how they engaged and stimulated people. They had arranged themed areas across the unit to help people be stimulated and involved with their surroundings. Themes included a powder room, hair salon, music area and sweet shop. Transport was available and people had the opportunity to go out on trips and these included trips to the coast, town and countryside.

Good

Is the service well-led?

Our findings

The home had a registered manager who had become registered as manager for Fellingate Care Centre in May 2016. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

Staff we spoke with were positive about their management and had respect for them. Staff commented, "The manager is approachable" and "There's good management, I'm well supported." Relatives also told us the registered manger was approachable. Their comments included, "There's an open door" and "If I had any problems I'd see the manager."

The atmosphere in the home was friendly. People told us the atmosphere was warm and relatives and visiting professionals said they were always made welcome. Staff, people and relatives said they felt well-supported. Their comments included, "Improvement of the service, especially the dementia care unit, it's amazing", "I'm always made welcome when I visit" and "Staff are very helpful."

The registered manager assisted us with the inspection, together with the deputy manager and the directors of operations. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and provider's representative were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

Staff told us monthly staff meetings took place and minutes of meetings were available for staff who were unable to attend. Staff meeting minutes from December 2016 showed topics discussed were separated into areas to cover quality issues, reflective practice, culture, policies and procedural updates and person centred care. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Staff comments included, "Staff meetings happen every four-six weeks" and "Staff meeting minutes are available that we all have to sign to show we've read them."

Auditing and governance processes took place within the service to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. All audits showed the action that had been taken as a result of previous audits.

Regular analysis of incidents and accidents took place. The registered manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. Records showed where a person had fallen more than twice they were referred to the falls clinic. Staff meeting minutes showed if an incident occurred it was discussed at a staff meeting.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. The registered manager completed some daily audits such as a daily walk around the building to check the environment and check morale of staff and people who used the service. Monthly audits included checks on health and safety, medicines management, care documentation, training, kitchen audits, accidents and incidents, hand hygiene, first aid and infection control. Six monthly audits were carried

out for infection control, moving and assisting and health and safety. We were told monthly visits were carried out by a representative from head office who checked the environment, spoke to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the registered manager to ensure they had acted upon the results of their audits. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned.

The registered manager told us the registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out regularly to people who used the service and staff. Surveys were carried out by the provider and results were available on behalf of people who had responded. For example a food survey was carried out in May 2016 that showed people's comments and suggestions for improvement. An action plan was available to show identified areas for improvement as a result of the feedback. We saw the results had been analysed and feedback was available showing what action was to be taken as a result of the survey. There was an electronic feedback device to capture relatives and visitors feedback when they visited the home. The results were analysed by head office and a report of the results was available within the home. A daily survey was also completed by a sample of people and relatives on each unit. Based on the question 'Are you happy with our service', it covered areas such as activities, cleanliness and food.