Bupa Care Homes (ANS) Limited

Druid Stoke Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection site visit took place on 9 November 2017 and was unannounced.

Druid Stoke 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 is run from two buildings located next to each other. One building provides nursing care and the other provides residential support.

There was a registered manager for the service .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.

Following the last inspection in October 2016, we asked the provider to complete an action plan to show what they would do to improve the outcomes in safety, effectiveness and being well led to at least good. We found that the provider had taken action in these areas and met the requirements of the action plan.

Where people had the capacity they were now well supported in making decisions about how they wanted to being cared for. There were now effective systems in place that helped ensure staff obtain consent to care and treatment in line with legislation and guidance. When people did not have the capacity to consent, their care needs were assessed in line with the Mental Capacity Act 2005 (MCA). Staff had completed MCA and knew about supporting people to have the right to make decisions in their daily life as well as to take risks. Staff also knew how to act in someone's best interests.

Staff recruitment procedures had been 'tightened up 'and improved. There were systems in place to reduce the likelihood of unsafe and unsuitable staff being taken on at the home.

There were now effective quality checking systems being used to monitor the service and overall experiences for people who lived at the home. This helped ensure people always received care that was personalised to their needs. Quality audits now picked up where improvements were needed and actions were then implemented to address the areas concerned.

People told us they that they felt safe and secure at the home and they confirmed for us that staff were kind and treated them in a respectful way. When risks to people were identified suitable actions were implemented to reduce the risks of people being harmed in anyway. The risks of abuse to people were further minimised as staff were competent in their understanding of abuse and how to keep people safe. The team were trained to know how to report concerns without delay.

Staff provided people with care that was safe as there were enough suitably qualified staff. Some people told us they felt at times there should be more staff on duty. Some people said staff sometimes seemed

rushed and did not have as long to talk with them as they would like. Overall our evidence showed that the numbers and skill mix of staff deployed at any time of the day or night meant peoples' needs were met in a timely manner.

People told us how much they liked the programme of regular one to one and group activities taking place in the home. Some people on the nursing side of the home felt that they would like more entertainers to perform there and, more one to one time with the activities coordinator The registered manager had identified this feedback already from their own consultations with people at the home . They were taking actions to review the activities that took place for people who lived on the nursing side of the home.

People were provided with a varied diet that suited their needs. People spoke highly of the menus and told us that they liked the food and also that they were offered choices at each mealtime.

People who lived at the home and the staff had built up positive and caring relationships. This also extended to include relatives and friends. Staff knew how to maintain the privacy and dignity of people and acted upon this understanding when they supported people.

Care was personalised and planned in a flexible way with people. Care plans were informative and set out for staff the actions to follow to meet people's range of care and nursing needs. Staff understood what was written in each person's care records and they knew how to provide care that was flexible to each individual and met their needs.

People were supported by a team of well trained staff. The staff had attended regular training and were developed and supported in their work. This helped them to improve and develop their skills and competencies. Nurses were able to go on regular training and updating of their skills. This was to help them know how to provide nursing care based on up to date practice.

People knew how to complain and how to make their views known as well as how to offer suggestions for improvements at the home .The views of people and their families were proactively sought by the provider and the registered manager. Suggestions and feedback were taken very seriously and were acted upon with changes made to the services where possible.

Staff spoke positively of the registered manager as well as the management structure of the organisation. The staff felt that the registered manager and senior managers provided strong and supportive, as well as effective, management and leadership. The staff team told us they were well supported by the registered manager who spoke positively about their role. Staff said they saw them every day and they were always there when they needed support and guidance.

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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

Medicines were stored and managed safely. People were given the medicines they needed safely and when they were required.

People felt safe living at Druid Stoke and they also felt safe with the staff who provided them their care and support.

Staff knew their responsibilities in relation to safeguarding people from harm and abuse.

Is the service effective?

Good

The service was effective

People were assisted by staff who knew about the Mental Capacity Act 2005 and its implications for people in a care setting
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People were supported to eat and drink enough to maintain their optimum health.When people were at risk of poor nutrition or dehydration action was taken.

People were supported with their different care needs by a team of well trained staff. The staff had the understanding and insight to to provide effective support that met the needs of the people they supported .

People were well supported to access to the services they needed for their health and well-being.Staff worked with GPs and healthcare professionals so that their health care needs were met.

Is the service caring?

Good

The service remains good

Is the service responsive?

Good

The service remains good

Is the service well-led?

Good

The service was well led

Quality checking audits were in place that were effective. They identified any shortfalls in the service and these were acted upon .

People and staff told us they thought the home was well run and the registered manager was doing a very good job.

Staff felt there was an open culture at the home. People also felt they could raise any concerns and these would be dealt with properly

Druid Stoke Care Home

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.

Before the inspection we used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed other information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

This inspection took place on 9 November 2017 and was unannounced. The inspection team consisted of three inspectors 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.

We spoke with 29 people who lived at the home. We interviewed 11 members of staff. We pathway tracked the care of six people. We saw care and support in communal areas, spoke with people in private. We also looked at records that related to how the home was being run as well as the quality monitoring systems in place.

Good

Is the service safe?

Our findings

At our last inspection in October 2016 we had found that people were not always kept safe because safe recruitment procedures were not always followed. At this inspection we found that action had been taken so that risks to people from unsafe staff being recruited were minimised. The provider now had a recruitment procedure in place that aimed to keep people safe by minimising the risks of unsuitable staff being taken on. We saw that all potential new staff could only begin work after a number of checks had been completed. These included references, proof of identification and criminal records checks. Staff we spoke with told us they had undertaken these checks. Disclosure and Barring checks were carried out on all the staff. There was proof of identification in the form of passports in place for all staff. There was also a probation period that all new staff were required to work. This could be extended for a longer period of time if there were any concerns about the suitability of new staff to work at the home.

People told us they felt safe living at the home. One person said, "Well, I don't feel unsecure here". Another person said, "Yes, it's very safe here". Further examples of what people told us included ," I feel safe but not sure why", "No one has ever been aggressive towards me" , "Yes, I feel safe, but I haven't really thought about it" and, "I feel safe ."

To access the home, visitors had to ring the bell and wait for staff to open the front door. This helped reduce the risks to people who lived at the home from unsuitable people trying to enter. There were systems in place to help to protect people from abuse and harm. Staff members we spoke with had undertaken adult safeguarding training within the last year. They were able to identify types of abuse, recognise the signs of abuse and knew the correct safeguarding procedures. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy.

Staff described how they would 'whistleblow' if their concerns were not resolved to their satisfaction. One staff member told us, "I get training every year. If I saw abuse I would defuse the situation and immediately report it to the manager". Another member of staff said "If I had concerns I would go to the home manager, but if I felt nothing was being done I would whistleblow to CQC".

The registered manager demonstrated that any safeguarding concerns were recorded, investigated and shared with outside agencies. From viewing the safeguarding records we noted that all concerns or incidences had been shared, action taken where necessary and the concern resolved. If the service had concerns about the care or treatment given to people living in their home by outside agencies, they reported their concerns to the local authority safeguarding team.

There was enough suitably trained and competent staff to meet the needs of people living at the home and keep them safe. This was evident in a number of ways. Many people told us there was enough staff to care for them safely. One person said, "There is enough staff, sometimes I have to wait, but never too long." Some people said they felt that they felt sometimes more staff were needed. Examples of the comments they made included; "Sometimes they have enough staff but not always" and, "There are not enough staff there to busy they rush in and have no time to talk to you they do their best."

We saw staff provide prompt one to one support to people who needed extra assistance with eating and drinking and with their care needs. Staff were also readily available when people needed two staff to help them with their mobility needs. Staffing levels were assessed weekly, or when the needs of people changed to ensure people's safety. The registered manager told us, "The clinical lead and other staff meet every Friday to assess the dependency of people in the home and staff numbers change depending on need." We noted that the number of staff who worked in the home were the same as the numbers on the duty rota. An additional member of staff worked one day so they could escort a person to an appointment in the community. One member of staff told us, "There is generally enough staff to do the job properly." Another said, "Most of time there is enough time to do my job but you need to manage your time well." Our own observations identified that care and support was delivered safely by appropriate numbers of staff.

Risks relating to the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm tests and fire drills took place to ensure that people and staff knew what action to take in the event of a fire. Gas, electrical and fire safety certificates were up to date and renewed as required to ensure the premises remained safe. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. 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. These individual evacuation plans were reviewed weekly to ensure they were up to date. Generic and individual health and safety risk assessments were in place to ensure staff worked in as safe a way as possible.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them, and protect people from harm. Each person's care and support plan had an assessment of any risks due to the health and support needs of the person. The assessments detailed what the activity was and the associated risk, and guidance for staff to take to minimise the risk. There were also additional risk assessments to meet people's individual needs; for example one person had a self-medication assessment whilst another had a bed rails risk assessment.
Staff continued to take appropriate action following accidents and incidents to ensure people's safety and this was recorded in the accident and incident books which also recorded near misses. We saw this contained specific details and any follow up action to prevent a reoccurrence. The registered manager analysed this information for any trends which could then be further investigated.

We observed medicines being administered by a member of staff who had good rapport with people. They took care to ensure that the correct medicine was administered to the correct person. The member of staff then completed the person's medication administration records (MAR) chart correctly. The medicine charts, contained information of people's allergies and how they wanted to take their medicine. All medicines had been administered and recorded. The care records showed one person who was reluctant to take their medication had been discussed by the staff, their doctor and close relative. Following an assessment of the person's mental capacity, it was agreed it was in their best interest to continue to give them their medication disguised in food.

Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely. On the day of our inspection we identified incorrect recording of the amount of liquid medicine left in a bottle. This discrepancy was immediately dealt with by the nurse in charge and appropriate action taken.

Infection control procedures were in place and the home had a comprehensive infection control policy and guidance for staff. The manual explained the role staff had in maintaining standards of cleanliness and

dealing with diseases. Staff had access to appropriate personal protective equipment (PPE) such as gloves and aprons when necessary. We saw staff using protective clothing whilst giving personal care to people and at meal times.

There were systems in place to ensure that the environment and equipment was cleaned regularly. The domestic staff had a range of cleaning products to keep the home clean and hygienic. The bathrooms were properly equipped with soap dispensers, paper towels, lidded bins and notices for people to read on hand washing. There were also sanitiser liquid dispensers available throughout the home for everyone to use to disinfect their hands.

Good

Is the service effective?

Our findings

At our last inspection we had found that the home was not always effective because some staff did not fully understand the legal implications for people around The Mental Capacity Act 2005 (MCA).
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. The registered manager was aware of their responsibilities with regards to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA).

At this inspection we found that care plans of people who had been assessed as lacking capacity to make decisions about their health and welfare were now in place. We saw that where decisions were required a mental capacity assessment had been undertaken for each specific issue, along with a record of the decision made in the person's best interests. Examples included the removal of bed rails and the use of a crash mat placed by the persons bed to reduce the risk of injury should they fall. Best interest decisions seen had been reviewed monthly and, although not signed by any other interested parties such as relatives or general practitioners, the content of the records indicated they had been contacted. A Deprivation of Liberty Safeguarding (DoLS) assessment had been applied for but had yet to be carried out. Staff spoken with confirmed they had received training around capacity and DoLS. We asked a care assistant what they would do if a person who lacked capacity refused the support they offered. They replied, "You absolutely respect them. You can talk to them and explain to them and if not you can always come back later."

People and relatives told us that they felt they received care and support that was effective and met their needs. Examples of what people said included; " Since I've came in here to view it it's like Buckingham Palace its brilliant and that's on first opinion we came to pick this place because we saw a lady at the hospital and she gave us a list of homes and this was the only one we came to see", "I wasn't very well when I first come in here I had a broken arm and came in here on a stretcher and they worked on me really hard and look at me now much better and making me well", "Yes the staff are doing a good job " and, "We can come and go as we like we have been told we stay all night if we need to as long as we tell them, and we have been told that if anything happens they will ring us they have been fantastic up to now."

People and their relatives were positive in their views of the choice and quality of food that was provided. Comments made included, "The food is good", "We get a good choice and that's the same at breakfast as well as lunch and dinner and my favourite meal is liver and onions and we get that every three weeks and no I never get hungry at night", "The food is lovely and we get a choice" and, "It's very good there's only one snag is there's too much and we do get a good choice and I never get hungry at night and my favourite meal is fish Smoked Salmon and we do get it every now and again."

We saw a choice of water or other soft drinks were served with lunch. People were also offered tea, coffee, and other drinks throughout the day. There were snacks such as fruit and biscuits readily available for people in dishes in communal parts of the home .People could also help themselves to snacks between meals. We saw people being served breakfast and lunch. The dining room experience for people was relaxed and welcoming. There was also a relaxed atmosphere between people and staff. The staff engaged with people and told them or showed them what the food was at meal times. The team were organised and communicated among themselves effectively toensure people were served their meals promptly.

One person had been assessed as being at risk of malnutrition. They required full assistance to eat and drink, and needed a pureed diet. We saw that staff provided this during our visit and records indicated that there had been no significant weight loss over a sustained period. We spoke with the chef manager who was able to tell us the people in the home that had lost weight or were at risk of doing so. They told us that they attended clinical meetings where they were informed about people who were at risk. They stated that where required meals were fortified with full cream milk, butter and cream. Snacks were available during the day if people needed or wanted them. Individual records of people's nutritional requirements were available in the kitchen. Staff confirmed that they were able to get food for people outside of the planned mealtimes. Menu's seen offered a choice of a cooked breakfast and a range of cereals, porridge, yoghurts toast and fruit. Lunch and evening meals offed a choice of two main dishes or alternatives on request. Menus were rotated weekly over a four week period. Meals were varied and appeared nutritionally balanced.

People were supported to maintain good health and to access healthcare services and receive healthcare support when needed. One person told us, "I see the GP on a Tuesday if I need to, I do have pain as I have kidney stones and yes I've seen the Dentist he comes here and if I need anything done I go to the clinic and yes I've seen the Optician" and, " Yes, I've seen the GP, but I haven't been to the Dentist, but I think I should see the Optician for reading glasses and I have seen the Chiropodist". People's care files contained records that showed they had been supported to access healthcare professionals such as general practitioners, opticians, chiropodists. The home had developed good communication links with local GP practices and other professionals, such as tissue viability specialists.

People's individual needs were supported by the adaptations and design of the home. We saw that the nursing wing provided single room accommodation over three floors, which were accessible by stairs or lift. There was a sitting room and a dining room on the ground floor. All areas were accessible for wheelchair users. Some ensuite facilities were available along with communal toilets and bathrooms.

New staff were properly trained and supported. The Clinical Service Manager told us about the induction procedure for staff. The said that the first five days were classroom based training sessions. Staff then spent a day working in all departments of the home in order to gain a perspective on other people's roles. They then worked shifts with an experienced member of staff until they were assessed as competent within their role. We spoke with a new member of staff who confirmed that they had received induction training, had been mentored by an experienced staff member and had their competency assessed. They described their induction as, "Useful, absolutely" saying about their mentor, "Their door was always open for support or explanations". The Clinical Services Manager said that they worked at least one shift a week 'on the floor' in order to monitor staff competency and assess the level of care. A staff member praised the Clinical Support manager saying, "(Name) is in charge; she will tell people if they are not doing their job." Another said, "(Name) doesn't miss much."

A staff supervision system was in place. The Clinical Service manager said that the aim was to ensure staff were supervised at least once a month. They described supervisions as, "Proactive and a good learning tool." Annual appraisals were also held in the form of 'Performance Conversations' that had been recently

introduced. These looked at the staff member's outcomes for the year, future aspirations and development. With regard to assessing staff competency, the registered manager had overseen the introduction of competency assessments for care assistants. These covered subjects such as moving and handling, and nutrition and hydration. Assessments were currently ongoing but records indicated that since introduction 18 care assistants had been assessed with regard to moving and handling and seven for nutrition and hydration. The manager also reviewed the rate of staff supervision and records showed that staff received supervision every four to eight weeks. Staff spoken with confirmed that they had received supervision.

We saw records of completed assessments and where staff had been assessed as not having the required knowledge then action plans were completed stating what further training or intervention was completed. Staff received annual training updates in mandatory subjects and some specialised training was also available, such as dementia awareness, tissue viability and end of life care. Records of staff training were seen. These indicated that staff received mandatory training relating to food hygiene, MCA/DoLS, behaviour we find challenging, complaints, CoSHH, dementia, fire safety, infection control, medicine management, moving and handling, nutrition and hydration, pressure care and safeguarding. Staff training records were reviewed by the registered manager each month. The last review indicated that 84% of staff had completed their mandatory training, 6% had been assigned further training and 10% were overdue. Staff we spoke with confirmed the training they had received. One described this as, "Very good" but added that they felt they needed more training regarding mental capacity and DoLS.

Good

Is the service caring?

Our findings

People told us the staff showed respect for their privacy and dignity when they provided their care and support. One person told us, "I try to stay a little independent like when I've had my bath and I do things for myself". Other comments included; "I have a bath every other day and the carers help me and I only like female helping me not a male", "They always knock on my door before they come into my room they're very good," "I love it here it couldn't be nicer, good food good staff and I like my room and my son comes every day". Another comment was, "They always knock on my door and when there doing anything for me they always close the curtains and the door they always respect my dignity."

Staff members explained to us what they did to maintain dignity for people when they supported them. One staff member told us they communicated with people through each of the steps they went through when assisting with personal care. Staff also said they worked with people to engage with them and find out what they can do for themselves. We saw that staff made sure that the curtains were drawn and the doors closed when they were supporting people with personal care. We heard staff politely ask other people to give them space when they were in the same room as the person they were supporting with their personal care needs. We also saw staff knocking on bedroom doors before entering people's rooms. When staff were providing personal care people's doors were closed and these actions promoted their dignity. We saw how staff spoke to people with respect using the person's preferred name.

To help improve care outcomes for people so that it was provided in a more personalised way each person had an identified keyworker, a named member of staff. They were responsible for ensuring information in the person's care plan was up to date. They also took a lead in spending extra time with people individually when they could. Staff knew what the idea of person centred care was. They told us it meant to put the person at the centre of how care was planned for them. It also meant making sure people were cared for in the way they wanted. This could include for example, choosing what time they got up, what gender of carer supported them with intimate care, and what choice of meals they wanted.

The design of the home helped to ensure privacy was respected. The majority of bedrooms were for one person to occupy. This meant that people were able to spend time in private if they wished to. We met a married couple who were residing in a double room. All of the bedrooms we viewed had been personalised with some of the person's belongings. We saw people were able to bring photos and small items of furniture in to them to look more homely. There were also quiet lounges where we saw some people chose to meet with visitors for privacy.

We saw that the service received a lot of thank you cards and letters from relatives and friends of those staying at the home, in appreciation of the care that has been provided. We saw a number of these thank you cards displayed on a notice board in the home.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Staff were knowledgeable about people's individual care needs and were able to explain how they used the care plans to ensure care was given in the way the person preferred. Care plans seen were based on assessments of people's individual needs. They related to needs such as senses and communication, lifestyle, safety, moving around, eating and drinking, healthier happier life, washing and dressing, skin care, going to the toilet, mental health and wellbeing. A daily record was kept in care files which staff completed entering details of how the person had spent their day, or recording the support given to them.

Care plan files were kept in people's rooms along with a supplementary file that contained a short description of people's needs based on their care plans, as a quick reference guide for staff. Also kept within the file were topical medicine administration records, records of positional changes, moving and handling risk assessments, records of personal care, and food and fluid charts. Records seen relating to a person who required the full support of staff to meet their needs indicated that they received that support. They were having their position changed regularly and received personal care. They had a pressure relief mattress on their bed and no pressure sores. Their topical medicine administration record had been completed appropriately. A record of their food and fluid intake was being kept. Records indicated that the person had lost weight over the preceding months. They had been seen regularly by their GP and supplements had been prescribed. Staff endeavoured to support and encourage the person to eat.

All of the care plans we saw were comprehensive and contained detailed information and reflected how each person wished to receive their care. We also saw that people's likes, dislikes and preferences in their daily life were explained clearly. These included what type of support they preferred with personal care, as well as their preferred bed time and morning routines. Care records were being reviewed regularly where possible with the involvement of the person who they were written about. The care records contained detailed information and reflected how each person wished to receive their care. Care records also gave guidance to staff on how best to support people with more complex nursing needs. These included plans of care for people who needed dressings, and for people who had more complex mobility needs.

People were supported to take part in a variety of activities but some people on the nursing side of the home felt they did not always have enough to do. People told us, "Yes, we have Physiotherapy twice a week and we do have people come into do exercises and we have a quiz this afternoon and I like the activities here", "I don't like the arts and crafts, but I do like a sing song and quizzes."

A full time activity coordinator was employed, supported by two part time assistants who worked a total of 12 hours each; one at weekends. A specific budget was available for activities and the coordinator said that this had increased over the years. The home was divided into nursing and residential units in separate buildings. The majority of group social activities were held in the residential unit. The coordinator said that they tried to ensure that people from the nursing unit who wanted to be involved were taken over to the residential unit; however this was sometimes difficult to achieve. The said that they planned to introduce a regular activity session each Monday in the nursing unit.

Activities provided included quizzes, visiting performers, and occasional outings out. The home did not have a minibus and the manager had recently agreed to pay for taxis in order to help more people access the local community. The home was visited by groups of children such as from the local school, cubs and a group called Little Acorns, who were very young children accompanied by their mothers. A local church group also visited the home.

A staff member confirmed that regular activities were held in the home and described the activity coordinator as, "Very good; always around and enthusiastic". Another said, "We have fantastic activities here". Other activities included visits from external entertainers and outings during the warmer weather. Church services were held regularly which helped to ensure certain people's spiritual needs were respected. The home was set in its own gardens with a view onto a park area. People told us how in warmer weather they sat outside daily and had tea and enjoyed this activity.
A quiz was held in the residential unit lounge on the afternoon of our visit and was attended by 16 people. An artist was also there, who completed a sketch of one of the people in attendance. People were enthusiastic about the quiz and got involved without prompting. The activity coordinator was both informative and humorous and had a good rapport with those attending. All staff spoken with on the nursing wing felt that they would like to have more time to spend with those who spent time alone in their rooms, either due to choice or health issues. One said, "No one has enough time to spend one on one with residents". Another said, "We need more staff, volunteers or activity staff to come and spend more time with people. We can meet all their needs apart from time". There were activity and interaction records in peoples care files. One seen related to a person who, due to their frailty spent most of their time in bed. The record indicated that the person had been visited by activity staff for one to one support.

People felt their views were taken seriously and acted upon. One person told us, "They do have resident's meetings and I think they do listen to us". Other comments included, "The manager wants you to tell him how it is".
People told us they were given their own copy of the provider's complaints procedure when they first started using the service. The complaints procedure included the provider's contact details so that people could contact the right people to make a complaint. The procedure was available in an easy to read format. People told us that they knew how to complain, they said they would approach the staff or the registered manager if they ever had any concerns. Everyone we spoke with said they felt confident they could make a complaint to the manager or any of the staff. There had been two complaints made about the service over the last year. The complaints procedure had been followed and the registered manager had fully addressed the concerns that had been raised. A letter was sent to the person and this set out what actions were taken to resolve their complaint.

To find out the views of people who lived at Druid Stoke people were sent or given survey forms on a regular basis. The areas covered included their views about staff and support, their friends, their involvement in their care, and the way the home was being run. The feedback was very positive and the findings were displayed for people to see. People using the service were happy with their care. This showed how the provider actively sought people's feedback.

After the most recent residents survey a number of actions and changes had been put in place. People at the home had suggested instead of a cinema afternoon on a weekly basis, to have a cream tea and social chat afternoon instead. We saw that this had now been put in place. The arrangements for managing laundry had also been revised at the request of people at the home. Also based on feedback the chef and registered manager had gone round the home and spoken with everyone to find out how the menus could be improved. These suggestions had been acted upon. Recent resident's meetings minutes showed that people were very happy with the new laundry arrangements and the revised menus.

People told us they had been given a file when they came to the home that contained information about the services provided. This was to help them decide if they felt it was suitable for their needs. The information given to people was clear and it fully set out the services offered. This information meant people were able to make an informed choice about whether the service was suitable for their needs.

Good

Is the service well-led?

Our findings

At the last inspection we had found that the home was not always well-led because although monitoring systems were in place we found these were not always operated effectively or consistently to ensure the home was able to make improvements to ensure the delivery of high quality care.

At this inspection we found that quality monitoring systems were being used effectively to make sure that improvements could be made to the overall quality of care and service. This was seen in a number of ways. For example, the quality of service and overall experience of life at the home was being well monitored. Areas being regularly checked included the quality of care planning processes, management of medicines, staffing levels and training. When shortfalls were identified, we saw the managers had devised an action plan to address them. Social and therapeutic activities had recently been reviewed. This was to make sure people were satisfied with what was provided. The registered manager had been holding until very recently weekly drop in surgeries at the home on a Sunday afternoon. These were for people, visitors and staff to speak to the registered manger in an informal way about anything that they wanted to raise with them. This was a creative way for people to be able to communicate with the registered manager about things that mattered to them.

The senior staff and registered manager told us how learning took place and when any trends and patterns were identified, action was taken to minimise the risk of re-occurrence. Accidents and incidents which involved people living at the home were properly analysed and learning took place. We saw guidance was in place from other health and social care professionals to offer the person specialist advice. There was sensor equipment in place for people who fell more frequently. This was to alert staff if people moved without assistance when they were at risk of having a fall. Consent had been obtained before these actions were taken.

The staff had an understanding of the provider's visions and values. They knew they included being person centred in their approach with people, supporting independence and respecting diversity. The staff told us they aimed to make sure they always used and followed these values when they assisted people with their care. For example, staff said they helped people to make choices in their daily life in the way they preferred. Staff said they were encouraged to make their views known to the management.
We saw posters in the home encouraging staff to speak up and talk to the manager about ideas for good practice and also if they had any concerns .We also saw that staff team meetings were held on a regular basis. The staff said they were able to make their views known about the way the service was run or anything that they wanted to raise. A number of topics were raised at the meetings. These included the needs of people at the service, staffing levels, health and safety issues and staff training. We saw when needed actions were identified to follow up on. The staff told us they felt confident to report poor practice or any concerns, which they felt would be taken seriously by the management. There was an up to date reporting procedure in place to support them to do this.

People spoke highly of the registered manager. Examples of comments they made included, "He seems like a nice young man and yes I think he's doing a good job and, "He is new and I think he's going to be quite

good and he's getting things done like putting a standard lamp in the library". Staff told us that they received, "Great support" from the registered manager adding, "He's young and active and quick to sort things out". Another told us, "The manager's transparent, has clear ethics and is genuine about care". Another staff member described the Clinical Support manager as approachable and said that she always took action if any concerns were raised.