Assured Care Services Limited

The Heathers

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

Overall summary

The inspection took place on 15 December 2015 and was unannounced.

The Heathers provides accommodation and care for up to 25 people with a range of health needs. At the time of our inspection, there were 22 people living at the home. The Heathers is a large detached house on the outskirts of Worthing, situated close to public transport and within walking distance of local shops. All rooms are of single occupancy and the majority have en-suite facilities. Communal areas include a sitting room with sun lounge extension, dining room and smaller sitting area. The home is undergoing refurbishment and redecoration. Accessible gardens surround the home.

A registered manager was in post. 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. The day-to-day running of the home was the responsibility of the senior care manager.

People were protected from avoidable harm and abuse and felt safe living at the home. Staff were trained to recognise signs of potential abuse and knew what action to take. Risks to people were identified, assessed and

Summary of findings

managed so that staff knew how to mitigate people's risks. Accidents and incidents were reported and action taken as needed. Premises and equipment were managed to keep people safe. There were sufficient staff on duty at all times and before new staff commenced employment, the provider undertook all necessary checks, to ensure they were safe to work with adults at risk. People's medicines were managed safely and staff were trained in the administration of medicines. People were protected from the risk of infection and the provider had infection controls in place.

Staff were trained in all essential areas and additional training was provided as needed. New staff followed the Care Certificate, a universally recognised qualification. Staff received regular supervision from senior staff and attended staff meetings. They had a thorough understanding of the requirements of the Mental Capacity Act 2005 and associated legislation and put this into practice. People had sufficient to eat, drink and maintain a balanced diet. They spoke highly of the quality of the food provided. People had access to healthcare professionals and services as required. They were encouraged to personalise their rooms and the provider was undertaking planned improvements across the home.

People were cared for by kind and caring staff who knew them well. One person said, "I enjoy living here; they are very kind and helpful here". They went on to say, "The staff seem to get on well here too. I can't complaint at all".

Staff knew people's preferences, their likes and dislikes and how they wished to be cared for; they treated people with respect. People were involved in planning their care and care plans and risk assessments were reviewed monthly and signed by staff. As people reached the end of their lives, staff looked after them with kindness, respect and dignity.

People received care that was responsive to their needs. Before they moved into the home, the management team undertook pre-assessments to ensure everything was in place to meet people's assessed needs. Care plans provided comprehensive, personalised information about people. There was a programme of activities organised by a part-time activities co-ordinator. External entertainers came to the home and outings into the community were organised for people. Complaints were dealt with promptly and managed in line with the provider's policy.

The home was well led and staff felt supported by the management team. People and/or their representatives were asked for their views about the service by an independent social care consultant and action was taken as needed. Residents' meetings took place. The provider had a range of internal systems and audits in place to measure the quality of the service overall. The consultant also undertook regular inspections of the home and an independent audit and any recommendations were acted upon by the provider.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were protected from the risk of abuse and staff knew what action to take if they suspected abuse was taking place.

Risks to people were identified and assessed appropriately and guidance provided to staff on how to mitigate the risk.

There were sufficient numbers of staff on duty and the service followed safe recruitment practices.

People's medicines were managed safely and they were protected against the risk of infection.

Good

Is the service effective?
The service was effective.

Staff were trained in all essential areas to deliver care to people effectively. They had regular staff meetings and supervisions. Staff had a good understanding of the Mental Capacity Act 2005 and associated legislation and put this into practice.

People had sufficient to eat and drink and had access to healthcare professionals and services.

The home was in the process of being refurbished and redecorated.

Good

Is the service caring?
The service was caring.

People had formed caring, friendly relationships with staff. They spoke highly of the care they received and were happy living at the home.

Staff were cheerful and positive with people, they knew them well and understood how they wished to be cared for.

People were treated with dignity and respect and, as they reached the end of their lives, were supported to have a dignified, comfortable and pain-free death.

Good

Is the service responsive?
The service was responsive.

There was a range of organised activities available for people at the home and outings into the community.

Care was planned for people in a person-centred way and care records provided comprehensive information about people to staff.

Complaints were dealt with in line with the provider's policy and to the satisfaction of the complainant.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

People were asked for their views about the service and these were discussed with an independent social care consultant at residents' meetings so that appropriate follow-up action could be taken.

Staff were supported by management who were involved in the day-to-day running of the home and worked as a team.

A range of audits were in place to measure the quality of the service. These comprised internal audit systems and the consultant also undertook an audit of the services provided. Recommendations were acted upon.

The Heathers

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.

The inspection took place on 15 December 2015 and was unannounced. Two inspectors and an expert-by-experience undertook this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had experience of older people and dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. Before the inspection, we examined the previous inspection reports and notifications we had received. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, their relatives and staff. We spent time looking at records including five care records, six staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with 10 people living at the service and one relative. We spoke with the registered manager, the senior care manager, two care staff and the chef.

The service was last inspected on 5 January 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People were protected from avoidable harm and abuse. Everyone we spoke with told us they felt safe at the home and were treated with respect. One lady said, "Safe? Oh absolutely! We're well taken care of here". Staff had a good understanding of what action to take if they suspected abuse was taking place. One member of staff explained the different types of abuse such as physical, emotional, financial, sexual and institutional abuse. They added, "I would inform the manager" and said that if they were not confident the registered manager had taken appropriate action, they would report their concerns to senior management or to the local safeguarding authority. Staff had received training in safeguarding adults at risk and whistleblowing within the last year.

Accidents and incidents were reported and a total of 14 accidents or incidents were recorded in November and December 2015. Action was taken as a result of these to minimise the chance of reoccurrence, such as a referral to the Falls Prevention Team for further advice and guidance. All records contained a clear description of the incident and indicated whether it should be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). The provider took immediate action when issues had been identified. For example, one person had suffered a series of falls. Staff identified that the person may have been suffering from a urinary tract infection and consulted the person's GP. This was confirmed by the GP and successful treatment given. The incidence of falls reduced as a result.

Premises and equipment were managed to keep people safe. The maintenance log and an environmental audit showed that all relevant and up to date certificates were in place. These included fire safety servicing records, gas safety certificates, water temperature and Legionella testing and liability insurance. The home was undergoing refurbishment and redecoration at the time of our inspection. The decorators had left the home in a safe condition and were coming back after Christmas to complete the work. A fire alarm test was due to be carried out on the day of our inspection and one of the maintenance men visited every person in their rooms to warn them it was only a test and not to worry. Before people came to live at the home, a pre-assessment of their needs was undertaken. If specialised equipment was assessed as being required, then this was arranged before people moved in. A member of care staff said, "At pre-assessment, we make sure all the equipment is in place before they come in". The home had a platform lift, with doors on either side; this enabled people to enter and exit the lift easily, without the need to turn round.

Risks to people were managed to keep them safe. Some people were receiving support from healthcare professionals, such as a district nurse, in the management of their pressure ulcers and wound care; this was in addition to the day-to-day care from home staff. Pre-assessments, carried out before people came to live at the home, formed the foundation of the care plan and initial risk assessments were put in place promptly. We asked staff about their understanding of risk management and keeping people safe, whilst not restricting their freedom. One care plan showed how risks associated with mobility and medicines management should be addressed by staff and contained detailed information and guidance. Risk assessments were reviewed monthly and audited regularly to ensure they contained detailed and relevant information. Some staff had undertaken training in the positive management of challenging behaviours. For example, one person exhibited challenging behaviour from time to time. Their care plan contained a detailed behaviour plan, which outlined steps staff should take to distract the person or de-escalate the situation, whilst keeping other people and staff members safe.

There were sufficient numbers of suitable staff on duty to keep people safe and meet their needs. On the day of our inspection, the senior care manager and three care staff were supporting people. In addition, the chef, a domestic, laundry assistant and a maintenance man were working in the home. At night, two care staff were on duty. We asked care staff whether they thought there were sufficient staff and one said, "Not always – the mornings are the most difficult. We try to have three care staff on duty". This member of staff went on to add that they felt they did not always have time to chat with people. However, another member of staff thought staffing levels were good. We observed that groups of people were rarely left without a member of staff for more than a few moments. Call bells were responded to promptly by staff. We looked at the staff duty rota for the previous four weeks. The rota showed that staffing levels were consistent across the time examined.

Good

Is the service safe?

We asked how safe staffing levels were established by the provider. The provider used a formal tool to assess the changing care needs of people and calculated staffing levels accordingly.

Appropriate checks were undertaken before staff began work. Staff files contained recruitment information and criminal records checks had been undertaken with the Disclosure and Barring Service (DBS) to ensure people were safe to work in care. This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with people at risk. There were also copies of other relevant documentation including character references. Staff files were regularly audited to ensure the information they contained was relevant and up to date. A member of care staff talked about their recruitment, that they had completed a CV, had an interview with the senior care manager, was shown round the home and met with people and had their role and responsibilities explained to them. They confirmed that having completed a successful interview, they started work a month later, after their DBS had come through.

People medicines were managed so that they received them safely. We observed a member of staff administering medicines at lunchtime. The staff member checked the Medication Administration Record (MAR) chart, located the correct medicine and then waited patiently with each person as they took their medicines. They then completed and signed the MAR for each person to show the medicine had been administered successfully. When one person had been identified as preferring not to take their medicines in the morning, their GP had been contacted, who authorised the safe administration of the particular drug at any time of day which resolved the issue. We were told that two people managed their own medicines and had been appropriately risk assessed to do this. Their medicines were kept in a locked drawer and locked bathroom cabinet to ensure security. Where people required the application of patches to relieve pain, then staff completed a body map, to show which part of the body the patch had been affixed. This would prevent the same area of the body being used when the new patch was applied.

Staff received training in the administration of medicines from a leading pharmacy. In addition, the senior care manager undertook regular spot checks when staff were administering medicines to ensure their competency was maintained. Controlled drugs were managed safely and two members of staff signed the MAR when these were administered and also signed the Controlled Drugs Register. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and associated regulations. Medicines were ordered, stored and administered safely. Any unwanted or out of date medicines were disposed of safely.

People were protected against the risk of infection as the provider had effective preventive and control procedures in place. We spoke with the registered manager about infection control, looked at the provider's infection control policy and the latest infection control audit and cleaning rotas. The provider had two nominated 'leads' for infection control. These were two staff who were infection control 'champions', both of whom had undertaken additional training on infection control and were responsible for the day to day management in this area. We observed staff giving care in communal areas. All staff wore personal protective equipment, such as aprons and gloves whilst giving care, in line with the provider's policy. The cleaning schedule for the home was detailed and included each person's room, communal and staff areas. Staff had signed the schedule when cleaning was completed.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. A new member of staff talked about their induction, that they had spent two weeks' shadowing with the senior care manager and added, "Gradually I started working on the floor". As a senior member of care staff, they had started to lead shifts independently after a period of six weeks and felt that their induction had been thorough and enabled them to work confidently. New staff were required to complete the Care Certificate, covering 15 standards of health and social care. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The senior care manager assessed new staff members' understanding of the Care Certificate, as did an external trainer.

We talked with staff about the training they had received. One talked to us about the training they had completed in fire safety, dementia, health and safety, infection control, moving and handling and first aid. They said that they could always ask for additional training if they felt this was necessary and added that some training was on line and some was face-to-face. They had also completed a vocational qualification in health and social care at level 2 and 3. The training plan showed that staff had received training and updates in the following areas: Infection control, health and safety, medication management, moving and handling, fire awareness, safeguarding, first aid, food hygiene, person-centred care, care of people with epilepsy, record keeping and confidentiality and end of life care. Other training undertaken by staff included: Pressure area care, understanding dementia and care of people with diabetes. Staff were also encouraged with their continual professional development. For example, the senior care manager was going to work at another of the provider's care homes to widen their knowledge of dementia and was looking to start a level 5 management qualification.

Staff received regular supervision meetings with their supervisors. Supervision meetings and yearly staff appraisals for all staff had been undertaken or were planned, in line with the provider's policy. A member of staff confirmed they had supervision meetings every three months and an annual appraisal with the area manager. They told us, "We discuss if I've got any concerns and then, depending what it is, [named area manager] will try and sort it out". They added that their strengths, weaknesses and areas for improvement were discussed and said, "Basically things concerned with the daily running of the home"; they said they felt supported by senior staff.

Staff meetings took place and staff confirmed this saying, "Staff meetings take place as needed". We examined the minutes of the latest team meetings, both those for senior staff and meetings open to all staff. Staff were able to discuss matters of importance to them and the people they were looking after. However, the minutes did not contain a review of the minutes of the previous meeting or an action plan for the current one. This meant it was not possible to ascertain whether issues raised previously had been resolved. We brought this to the attention of the registered manager who stated they would ensure that actions arising were recorded and discussed in future staff meetings.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. 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. Staff had undertaken training in the MCA and Deprivation of Liberty Safeguards (DoLS). 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 registered manager had submitted four applications to the local authority under DoLS, one of which had been authorised. The others were still being considered by West Sussex County Council. Care plans showed that people's mental capacity was assessed on admission to the home and action taken if required. For example, one person had been subject to a best interests meeting due to exhibiting challenging behaviour and action was taken to keep them and others safe, whilst restricting their freedom as little as possible. This was in line with the MCA code of practice. Staff confirmed they had received training on the MCA. One staff member explained, "Well you have to ask them [referring to people]. You have to assume they have capacity, unless it's proven otherwise".

Good

Is the service effective?

People were supported to have sufficient to eat, drink and maintain a balanced diet. People had ready access to drinks at all times. For example, there were drinks available in the lounge and staff came round with tea and coffee trolleys in the mid-morning and afternoon. People could choose where they wished to eat their meals and many chose to eat in the dining room, where tables were laid with holly patterned cloths for the festive season. In addition, there was a Christmas tree which people had helped to decorate. At 12.15pm people started gathering for lunch and a total of 11 people sat at three tables, choosing where they wanted to sit. Placemats and cutlery were laid, with salt and pepper at each table. Drinks, consisting of a variety of squashes or water, were available.

On the day of our inspection, a three course lunch was on offer comprising chicken soup, roast gammon with cauliflower, peas and mashed or jacket potato and bread and butter pudding with custard. People could also choose an alternative option if they wished. Lunches were brought individually to people under plastic covers and we observed comments from staff such as, "Would you like some help with cutting that?" and "Where would you like the gravy poured, all over, or just the meat?" We observed a member of staff assisting one person, who had a visual impairment, with their meal. As they placed the food in front of them, the staff member said, "Would you like me to cut that up for you [named person]?" The person nodded their agreement. The staff member then explained where each food group was on the plate and put a spoon in the person's hand, which enabled them to eat independently. However, we observed the member of staff kept a discreet eye on the person and only interceded once when the person's spoon was too full. The person finished their meal and pudding at their own speed and later told us they had really enjoyed the food, particularly the soup and the pudding.

Four people praised the chef and the quality of food and comments were, "They are good with the food here. [Named chef] is really good", "The variety of food is good. [Named chef] tries to change things around for us. Praise to the chef, it just isn't the same if he's not on duty!", "We have a nice chef and very nice food" and "[Named chef] is a good chef. We get plenty of choice". Another person told us, "Well, I'll tell you about what I think. I wouldn't be alive if I hadn't come here. I wasn't coping at home, wasn't eating enough. I'd get a frozen meal for one and that would be all I ate in a day. My son brought me here and I'm glad he did! No, being here saved my life". A relative referred to the food and said, "I've see what's on offer and mum is really happy". We spoke with the chef who said that he planned menus on a four weekly cycle. He said that menus were discussed at residents' meetings and that people liked to have a roast meal at least twice a week and roast gammon every week. The chef said, "Some people like sandwiches as a snack" and said that cakes, biscuits, crisps and fresh fruit were always available. Special diets were catered for, such as for people with diabetes. The chef used high calorie foods such as full fat milk, cream and butter, for people who needed to increase their weight. Mealtimes were protected time for people, so that generally visitors were not encouraged during this time, to allow people to concentrate on socialising with other people and enjoying their meals. However, the senior care manager explained that this was flexible and people's meal times could be changed if people had special appointments they wished to keep.

People were supported to maintain good health and had access to a range of healthcare services and professionals. A member of staff said, "Usually the doctor visits here", however, staff also escorted people to attend their healthcare appointments. They explained, "If their relative can't come, we go with them". People had access to a wide range of external; health and social care professionals and care plans confirmed this. For example, hospice staff, speech and language therapists and ophthalmologists. Advice and guidance given by these professionals was followed and documented in the care plans. The senior care manager said, "I go round first thing in the morning and see people every day and check if anyone's unwell" and added that they communicated with relatives and healthcare professionals regularly.

The home was in the process of being refurbished and redecorated. The registered manager said that they had plans to redecorate the lounge in line with people's preferences. People were encouraged to bring their own furniture and to personalise their bedrooms. The layout of the home had made use of all available space and most bedrooms were en-suite, with plans to make further improvements during the refurbishment. We observed that bedrooms were of a reasonable size and nicely decorated.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed that staff were kind and affectionate with people and were patient with them; there was good natured banter between people and staff. One person said, "I know everyone now and I call all the staff by name. I like them, they have respect and good manners". Staff were caring, tactile and friendly with people, talking with them at eye level and referring to people by first names in line with their preferences. Most people preferred to have their bedroom doors kept open during the day and appeared to enjoy watching 'life going by'. People got on well with each other and some had known each other before they came to the home, whilst others had made friends with specific people once they arrived. There was a family atmosphere within the home.

One person said, "I enjoy living here; they are very kind and helpful" and added, "The staff seem to get on well here too. I can't complain at all". Another person said, "My husband died in my arms suddenly – I hated living alone. I'm so much better now I'm here". A third person said, "There's a good sense of humour about the place. You need that. The staff seem to cope – they're happy to have a chat and laugh!" Everyone we spoke with confirmed they were happy living at the home and that staff were warm, caring and friendly. One person reminisced about The Heathers before it became a care home, when it was a medical practice. They explained, "I remember it was the old surgery and I used to work near there and I knew the doctor here till he retired!" A relative said their mother was, "Definitely looked after" and, "I'm very happy with the care she's receiving". Another relative said they were thoroughly acquainted with their family member's care plan and thought the staff were, "Incredibly patient". The person referred to caused some amusement as they had wedged a clean, disposable bedpan on their walking aid which they used to carry their spectacles and other needed belongings. The person said, "It fits so well and it's handy!"

Staff were cheerful in their approach to people and supported them to express their views. One member of staff said, "The home is friendly and it's a nice atmosphere. I get on well with the residents". They added, "It's the little things that matter a lot to people" and talked about helping people to change their calendars at the start of each month. Another member of staff said, "We do get time with the residents, one-to-one time". We observed that staff spent time socialising with people, rather than just providing care. Care plans contained people's life histories and social assessments. They had been compiled in conjunction with people and their families where possible and contained information staff could use to help build relationships, for example, people's previous occupations and hobbies.

People were involved in their care. All care plans and risk assessments were reviewed monthly and signed by staff. There was evidence that people and/or their representatives had regular and formal involvement in care planning and risk assessment. As people's views were sought, there were opportunities to alter the care plans if the person did not feel they reflected their care needs accurately.

People were treated with dignity and respect. One member of staff said, "I knock on the door before I go in. I close the door. I always explain what I'm doing and make sure people are covered up and close the curtains". Each person's care plan contained a section which specifically addressed issues of dignity and privacy. For example, one care plan stated how the person would like to be addressed, if they had a preference for which gender of staff supported them and instructions to ask the person before intervening to offer help. All staff were also offered training in equality and diversity and maintaining confidentiality.

People were appropriately dressed for the time of year, with sensible footwear and their hair and nails looked clean and well tended. People who were reasonably mobile were encouraged by staff, with support, to be as independent as possible. People told us that they had complete choice as to what time they got up in the morning and went to bed at night. Some people preferred to eat meals in their rooms, rather than in communal areas.

We asked one member of staff how they would support people as they came to the end of their lives. They told us that they had done a course on end of life care and referred to dignity, respect and caring for people. They said, "If we can keep them here, we care for them here". They said they would check whether people were comfortable and the importance of talking to people, even if they were semi-conscious. They referred to treating people with

Good

Is the service caring?

kindness, respect and dignity. The management worked closely with a local hospice and staff from the hospice came in to provide emotional support and assisted with pain management to people if required.

Good

Is the service responsive?

Our findings

On the day of our inspection, people were listening and singing to carols and one person was busy writing their Christmas cards. There was an internal Christmas postbox which was used to post cards for staff and residents.

A range of activities was on offer every day of the week and we saw copies of the activities programme over several weeks. An activities co-ordinator worked at the home on Mondays, Wednesdays and Fridays. People were given a copy of the programme and could pick and choose what they might like to participate in. Activities were on offer such as: craft, board games, quizzes and external entertainers also visited the home. In addition, trips were organised and a trip to a local garden centre had taken place recently, which six people had enjoyed. People could also go out to visit local shops, accompanied by staff. People had easy access to the garden on a paved path and enjoyed gardening in the summer months. Some people had planted the flowers in the garden, which extended round the building. We asked people what they liked to do and if they were ever bored. One person said, "No, I'm not bored. As long as I've got the TV and nice food, I'm not worried about extra activities – it's just not my thing. [Named activities co-ordinator] does all the arrangements and she comes to see me and she's a lovely lady". Another person said, "I go out with my son quite often. We went for a walk today and had coffee in Marks and Spencer, it was nice. I read quite a lot, I knit spasmodically. I do take part in some activities, I'm not bored, no". A third person said, "I was in another place before here. It was an entertainer that recommended this place. She goes to them all you see and she was definitely right about this place! It supplies everything I need. I'm safe, the staff are nice, everything's fine and it's less expensive too!"

Pre-assessments were undertaken by the senior care manager and registered manager prior to people being admitted to the home. People's needs were discussed and the basis of a care plan could be put in place before people arrived which ensured a smooth transition. Care plans were divided into four sub-sections, including person-centred care planning and a care plan diary. (The essence of being person-centred is that it is individual to, and owned by, the person being supported.) Care plans contained detailed information about people's personal histories, likes and dislikes and their choices and preferences were documented. Daily records were detailed and showed that these were taken into account when people received care. For example, in their choices of food and drink. We looked at the provider's system for the communication of information concerning people's care between staff members. Copies of a daily report showed that residents' care was discussed at staff handovers and circulated to all staff, including members of the senior management team. The reports were detailed and relevant with action points highlighted in red. They contained information of action needed, the reason why it was needed and a nominated person to carry it out. Handover meetings were held between shifts at 7.45am, 1.45pm and 7.45pm; these lasted for 15-20 minutes and were held in the staff office. Staff were given a list of people who they would be supporting and one staff member said, "Our names are written down [on the list] next to the person we're supporting".

The provider's complaints policy and procedures were displayed in communal areas of the home. This included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the local government ombudsman. There had been four formal complaints made this year. The complaints had been resolved in a timely and effective manner and to the satisfaction of the complainant. The registered manager had written to the relevant parties with an action plan, where necessary, to prevent further reoccurrence of the issue. One member of staff said, "If someone had a complaint, I would talk to that person". They went on to explain that they would establish what the complaint was about and, if necessary, would refer this to the registered manager. A relative told us that they had never had to make a complaint.

Good

Is the service well-led?

Our findings

The managers at the home were approachable and pleasant, knew the home and people well and were frequently seen working alongside care staff and interacting with people. Staff morale appeared high and a good atmosphere prevailed at the home. We observed several members of staff approached the registered manager and senior care manager easily and without hesitation. The positive atmosphere of the home probably contributed to the general contentment of people living at the home. The senior care manager was in charge of the day-to-day running of the home and said they felt well supported by the registered manager and the provider's area manager. They said, "The teamworking is good here and the relationships we have with residents and relations". The registered manager said, "I like coming here. I feel I've achieved something. I try and get people out into the community". When asked about the culture of the home, the senior care manager said, "It's quite open and transparent – a homely environment for the residents. They feel safe. If there's anything they're not happy with, then they can approach staff or myself".

People living at the home and their families or representatives were asked for their views about their care and treatment. These were sought via completed satisfaction questionnaires on a yearly basis and undertaken by an independent social care consultant. The latest results of the 2015 survey included the views of 10 residents and four relatives. There were high satisfaction levels amongst people and their families, particularly in the area of quality of care and staff attitudes. The results of the survey were circulated and discussed at residents' meetings. People were invited to discuss the results with the consultant and make suggestions for service improvement. In addition, the consultant made themselves available to anyone to speak one-to-one if they preferred.

The provider undertook regular audits of incidents and accidents. These included evaluation of the documentation used, an evaluation of reoccurring incidents and environmental audits. The aim of these audits was to identify trends and to reduce the risk for people. An environmental audit showed that the premises were regularly checked to ensure the safety and welfare of people and staff. Areas included toilet flushing efficiency, maintenance of rooms and corridors and lighting systems. All issues identified were dealt with promptly by a named individual within a set timeframe.

The registered manager and area manager audited medicines monthly and documentation confirmed this. Where issues were identified as a result of these audits, these were addressed to maintain the safe and effective management of medicines. There were clear lines of accountability if issues arose. There were action plans attached to the audits with proposed dates of completion and a nominated person to carry them out. Medicines management was also externally audited, by the supplying pharmacy and by an independent social care consultant.

Monthly infection control audits were undertaken and if issues were identified, a time scale for completion was set, along with the person responsible for completing the work and a checking date. The provider also had regular infection control meetings with relevant staff. Minutes of the latest meeting related to issues such as laundry provision and the six monthly 'deep clean'. Timescales for the actions to be completed and staff responsible were identified. Cleaning was the subject of a regular audit, both internally and by the independent social care consultant.

We were shown a document relating to a follow-up visit by the independent social care consultant to the home, dated 19 November 2015. The consultant had undertaken their inspection of the home and made recommendations to the provider in a range of areas including: administration of medicines, staffing, staff training and supervisions, catering, care planning, activities and systems to monitor the quality of the service overall. Where recommendations had been made, the report documented what action had been taken as a result and linked with the internal audits undertaken by the provider. This showed that the provider had robust quality assurance systems in place to drive continuous improvement.