Scarborough Hall Limited

Scarborough Hall and Lodge 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 took place on the 21 and 22 June 2016 and was unannounced. At our last comprehensive inspection on 13 February 2015 the service required improvement because there was a breach of Regulation 12 relating to infection control. There were also five recommendations; these were about medicines, quality assurance, deployment of staff, supporting people with eating and drinking and how staff implemented advice from healthcare professionals. We carried out a focused inspection on 8 December 2015 to check that the provider met legal requirements. We found that they were no longer in breach of regulation 12 but the rating remained the same so that they could demonstrate good practice over time. At this inspection we found that the previous breach and a number of the recommendations made were now met.

Scarborough Hall and Lodge is registered to provide residential care for up to 85 older people who may be living with dementia. There were 82 people resident on the days of the inspection. The service is purpose built and has all single rooms over three floors; ground, first and second. There were older people living on the ground floor and people living with dementia on the first and second floors. There is a passenger lift to enable people to reach the upper floors. The service has pleasant grounds surrounding the home with themed gardens, a conservatory and well-maintained pathways.

There was a registered manager employed at 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.

Staff had been recruited safely and there were sufficient staff on duty to meet people's needs.

Staff were clear about what it meant to safeguard people and were aware of the procedure to follow when alerting senior staff about any incidents.

Accidents and incidents were reported and analysed to identify any patterns and themes.

Health and safety checks had been carried out and equipment serviced. The service was clean and tidy and the registered manager carried out regular checks of the environment to ensure this was maintained. There was a fire risk assessment in place and checks of the fire safety equipment had been carried out. Staff had received training in fire prevention and safety.

The environment was modern but at the same time homely. Signage was used as a wayfinding aid for people and there were rummage boxes and other items for people to use to recall memories.

Medicines were administered and managed safely.

Feedback about communication between staff and families was inconsistent but professionals said that

communication between themselves and the service was good. Improvement in this area would benefit relationships between relatives and the service.

The level of training provided for staff allowed them to provide the care required. They had a thorough induction where they completed training and shadowed more experienced staff. Senior staff provided supervision every two months and appraisals were carried out annually.

The service was working within the principles of the Mental Capacity Act 2005. When people were unable to make their own decisions their families and professionals were consulted.

When people needed support with healthcare needs staff made sure that their GP was aware and that referrals were requested.

Families and friends told us that they believed that staff cared but expressed frustration about what they saw as a lack of communication. Professionals told us that they had witnessed caring staff. Our own observations identified that staff were caring.

The staff were trained in palliative and end of life care in order to support those people who were reaching the end stage of their life. They were supported through training and visits by staff from the local hospice.

People were invited to share information through care planning. They could share their views by completing surveys, attending meetings or by talking to the registered manager.

People who used the service had a care plan and risks to their health had been identified. The care plans were reviewed and evaluated monthly. In addition reviews were carried out with social care and health professionals. Some of the relatives we spoke with told us that they had attended reviews.

A varied programme of activities was available for people who used the service. In addition there was a hairdressing salon on the premises which was open four days a week and visits within the local community organised.

Complaints were managed according to the service's policy and procedure.

There was a quality assurance system in place. Audits were carried out regularly and feedback gathered through surveys.

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.

Staff were recruited safely and had all appropriate checks in place before starting work at the service.

There was a safeguarding vulnerable adult's policy and procedure in place and staff were trained to identify signs of abuse and knew how to report any incidents.

Health and safety checks of the service had been carried out and were up to date.

Is the service effective?

Good

The service was effective.

The environment was modern but homely and reflected dementia friendly principles.

Communications with relatives were not always consistent; on balance we considered that it was effective although improvements in this area would improve relationships between families and staff.

Staff received training which appropriately supported their role. They had regular supervision and an annual appraisal.

Is the service caring?

Good

The service was caring.

We observed positive interactions between staff and people who used the service.

Information was shared about people's needs through care planning and information of interest was displayed in the service via notice boards and discussed in meetings.

Staff were trained in palliative and end of life care and were supported by staff at the local hospice.

Is the service responsive?

Good

The service was responsive.

People had a care plan that reflected their needs and risks to their health were identified and risk management plans put in place.

Care plans were reviewed and evaluated regularly.

People had access to a varied programme of activities. A history of people's lives was gathered in order to help staff provide for their interests and their views were sought at regular meetings with the activities co-ordinator.

Is the service well-led?

Good

This service was well-led.

There was a quality assurance system that identified where improvement were needed.

There was a manager employed who was registered with CQC. They kept up to date with best practice through attendance at management training provided by the company and membership of a group which provided regular updates about legislation and guidance.

Staff were kept informed of any developments through regular staff meetings.

Scarborough Hall and Lodge 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.

This inspection took place on 21 and 22 June 2016 and was unannounced. On the first day of our inspection, the inspection team was made up of two Adult Social Care (ASC) Inspectors. On the second day, the inspection team was made up of three ASC Inspectors.

Before our inspection, we asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and what improvements they plan to make. We looked at information we held about the service, which included information shared with the Care Quality Commission via our public website and notifications sent to us. Notifications are made by registered providers to give us information about changes, events or incidents that occur within the service. We contacted the local authority's quality assurance and contracting team to ask for their feedback about the service which was positive. We used this information to plan our inspection.

During the inspection, we spoke with seven people who used the service and observed their daily routines. In addition we spoke with three people who were visiting their relatives or friends. We spoke with the registered manager, deputy manager, eight care workers and the chef.

We looked at eight people's care files, ten staff recruitment and training files, records relating to the management of medicines within the home and a selection of records used to monitor the quality of the service such as audits, staff meeting minutes and policies and procedures. We observed medicines being administered, activity sessions and a lunch time period.

Following the inspection we contacted a district nurse, a social worker and a clinical nurse specialist to gather their views about the service. Their comments have been included in the report.

Good

Is the service safe?

Our findings

People who used the service were not always able to tell us whether or not they felt safe and feedback from relatives and friends was not consistent. Although we saw that there were sufficient staff on duty, in some areas of the service they were not as visible at periods of high activity such as meal times particularly on the first floor. Despite this, our observations led us to believe that the service was safe overall.

In relation to staff deployment we observed on the first floor on day two of our inspection that people using the service had congregated around the entrance to the dining room after their meal, as they waited for direction and support from the staff on duty. This created some degree of confusion and appeared rather chaotic for a short period of time. We also observed periods where there was no staff present to supervise and engage with people who were living with dementia in some of the communal areas on the first and second floors. We were able to share these observations with the staff on duty and have further reviewed them with the regional manager since the inspection.

One relative told us, "Yes I do think [name of relative] is safe" but a second visitor to the service told us, "I can't say he is safe here because someone [another person who used the service] attacked him last week." We explored this further and the registered manager told us the person had been moved to a different area within the service. The incident had been properly reported and investigated. A third visitor said, "Yes, I do" when asked if they thought their relative was safe. They went on to say, "You won't find anything wrong here."

One member of staff told us, "There are enough staff for the most part but it depends on whether people are off sick." Staff rotas, which were planned in advance, confirmed that levels of staff had been consistent over time so the numbers of staff on the day of our inspection were typical of the usual staffing levels. Although the needs assessment showed sufficient numbers of staff were on duty there were times when staff could have been used more effectively in managing busy periods.

The registered provider had taken steps to safeguard people who used the service and had a safeguarding vulnerable adult's policy and procedure in place for staff to follow. Training had been provided to staff on how to respond to safeguarding concerns. We noted that a small number of staff needed to update this training. Despite this, our conversations with staff showed us they understood their role in identifying and responding to safeguarding concerns. A district nurse told us, "People are safe, no concerns around safeguarding."

Records showed that safeguarding concerns were appropriately investigated in consultation with the local authority's adult safeguarding team and action taken to promote and maintain people's safety. There was a whistleblowing policy in place and a member of staff told us, "If there is any problem I know I can go outside the service or to the area manager until the problem is dealt with."

Each person who used the service had risk assessments in place where needed. These contained individualised assessments which identified potential risks to people who used the service and to the staff

who supported them. Risk assessment tools were used to determine the level of risk to people's health and gave details of how support should be provided to reduce those risks and promote people's safety. For example, where someone who used the service was at risk of choking this had been scored to show the level of risk. The corresponding risk management plan documented the level of support required from staff. This showed us risk assessments were being appropriately used to promote people's health.

We asked staff how they kept people who used the service safe. One person told us, "Everything we do is risk assessed so that the resident's safety is highlighted."

Where accidents and incidents occurred a record was kept of what had happened on a Datix system. This is an online patient incident reporting system. If a person had an accident the member of staff dealing with the incident would complete the details on to the system. We saw that accidents and incidents were reviewed by the deputy or registered manager to ensure that appropriate action had been taken. Information relating to accidents and incidents was analysed and patterns or trends identified. Systems were in place to monitor accidents and incidents to reduce any future risk of injury or harm.

There were records in place which showed us that health and safety checks had been completed. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, gas services, water temperatures, electrical items and all lifting equipment including hoists and the passenger lift.

A suitable fire risk assessment was in place and regular checks of the fire alarm system, fire extinguishers and emergency lighting were carried out to ensure they were in safe working order. Fire safety training took place to ensure that staff knew how to respond in the event of an emergency. Personal Emergency Evacuation Plans (PEEPs) were used to document the level of support each person who used the service would need to evacuate the home. This ensured that staff had the necessary knowledge and skills to support people and maintain their safety in the event of a fire.

We were told by the registered manager that 'daily walk arounds' were carried out to ensure that any damage was identified and broken or dangerous equipment was repaired or replaced at the earliest opportunity. We observed that one person's profiling bed was not working. A profile bed is a bed that can be adjusted using a hand set. The need for a replacement bed had been identified by the registered manager and ordered. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe equipment. A district nurse told us, "I have seen staff using the equipment people need, safely, they appear to be trained well and I have not seen anything to make me concerned."

Appropriate recruitment checks were completed before staff started work. Records showed new staff were required to have an interview, provide references and Disclosure and Barring Checks (DBS) checks were completed. DBS checks provide information to employers about any criminal convictions or cautions and identifies whether or not a person is barred from working with certain groups of people. This showed us systems were in place to ensure only people considered suitable to work with adults who may be vulnerable had been employed.

We saw that there was a disciplinary policy and procedure and this was issued to staff when they began working at the service. We looked at the files of two staff that had been subject to disciplinary processes and saw that these had been carried out according to the service policy and was clearly recorded with outcomes noted. The provider used employment law to ensure that any unsatisfactory behaviour by staff was dealt with appropriately in order to safeguard the people who used the service.

Medicines were managed and administered safely. They were securely stored in locked medicine trolleys in designated rooms and checks of the medicine room and fridges were completed to ensure medicines were stored at the correct temperature. Staff responsible for administering medicines worked in line with the company policy and procedure .Medicine administration records (MAR's) were completed correctly. We carried out a random stock check of the controlled drugs (CD's) and found stock to be correct and matched the records kept in the CD book. CD's are medicines which require stricter legal controls to be applied to prevent them: being misused, being obtained illegally or causing harm Training was provided to all staff who administered medicines and we saw that this was up to date .

The service was clean and tidy during our visit. There were cleaning rotas in place and these were completed by staff. A relative of someone who used the service said, "The people who clean are fantastic." We saw that there was a contract in place for clinical waste to be collected and that this was done regularly. Laundry was placed in specific containers on each floor and then brought to the laundry. The laundry provided dissolvable bags for soiled laundry and the washing machines had a sluice wash programme. These measures assisted in the prevention of infection.

Good

Is the service effective?

Our findings

One person who used the service told us, "Its well run here; methodically."[They referred to staff being organised] A visitor told us, "Staff recognise when [relatives] behaviour changes. One staff, I believe, saved his life by being vigilant." Another told us, "Staff are very good and know what they are doing." However a relative told us, "They could communicate more."

We looked around the service and saw that it was clean and tidy with modern decor. The building was purpose built and felt homely and comfortable. There were two lounges and a dining room on each floor giving people ample communal space. The furniture was comfortable yet practical. For instance the chairs were in a comfortable fabric but were washable ensuring that they remained clean. People's names and photographs were on their bedroom doors to help them find their way to their rooms and that extended to the communal areas where there was also signage. Signs can be very helpful to people living with dementia if they are clear, mounted low enough; have words and a picture and contrast with the background.

There were rummage drawers, hats, scarves, coats, jewellery, books and magazines for use in alleviating people's need for stimulation and giving them activities to fit with the short attention span experienced by many people living with dementia. The environment was dementia friendly.

Communication was not always consistent between staff and families. The staff told us that when they recorded incidents on the Datix system it provided reminders about informing families. However, the varied feedback from relatives showed that this did not always happen immediately. Improved communication would benefit both people who used the service and their families and help build positive trusting relationships. One relative told us, "The GP visited last week and they didn't tell me what happened until I came in." Another told us, "They always contact me straight away." Although people were told of any events that affected their family member when appropriate it could be timelier.

Professionals told us that communication with them was good. A social worker told us, "The Manager, [Name] communicates with me well and always responds quickly to any queries I have" and a hospice clinical nurse specialist said, "They are good at ringing us or referring in for support." A district nurse said, "Communication is good and they follow our advice. We sometimes need to remind them about things."

The training and induction programme equipped staff with the skills needed to carry out their roles effectively. We saw that training was provided on topics which included health and safety, infection control, fire safety, safeguarding adults, moving and handling, medicines and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The registered manager showed us a training matrix, which recorded training staff had completed. The matrix showed that some staff required updated training. We saw on the notice board that some of those courses had been booked and staff confirmed this.

We saw that new staff received an induction before they started work and then shadowed more experienced

staff. One member of staff told us "I had a good induction" and another said, "I had three days training." A third member of staff told us, "I was shadowed before working on my own; had a good induction."

Staff we spoke with were positive about the training provided, with one care worker saying, "There is enough training. The team leaders do some of the training" and, "I have more training coming up. There is plenty of training. The dementia training we did was wonderful and helped me communicate with people with dementia." Throughout our inspection we observed staff providing effective and competent care to meet people's needs.

Supervision was provided for staff every two months in order to give them support. Supervision is a process, usually a one to one meeting with a senior member of staff which provides an opportunity to discuss people's care needs, identify any training or development needs and address any concerns or issues regarding practice. Staff had last received supervision in April and May 2016. Records of supervisions completed showed that the issues discussed were recorded and agreed by staff and supervisor. Appraisals were completed annually. One care worker told us, "I had one to one supervision last week."

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. At the time of our inspection everyone who used the service was either subject to DoLS or had a pending application for DoLS. The registered manager understood their responsibilities under DoLS and had a system in place to monitor any conditions and when the authorisation expired to ensure that new applications were submitted.

Care plans showed that consent to care and treatment was sought in line with relevant legislation and guidance. Where there were concerns about people's ability to make a decision, mental capacity assessments had been completed and if necessary best interests decisions made regarding the care and support provided. A visitor told us, "They ask me as his power of attorney for consent but they also ask him."

We observed lunch being served and saw that people were offered a choice of what to eat. There was a menu board in reception which identified a choice of two meals at lunch and dinner. In addition there was a selection of hot and cold deserts available. The food looked appetising and nutritious. People's meals were served from a hot trolley and so appropriate portion sizes were provided according to people's needs and wishes. People were supported and encouraged to eat and drink enough and left to take as much time as they needed to enjoy their meal. People who used the service had drinks and snacks available in lounge areas and could help themselves. A relative told us, "Everyone here is well fed."

The chef told us that food passports for people were completed on admission. These identified peoples nutritional and hydration needs. The chef held details in the kitchen of anyone with allergies and people who required food to be served in a specific way such as pureed. This ensured that people received food safely in accordance with their specific needs which reduced any risks for them and maintained their health and wellbeing. There was a four week menu in place and the chef had menu cards which contained

nutritional values for the food showing that people received a nutritious diet.

The dining room tables were set with table cloths, serviettes and cutlery and had flowers on the tables. There was friendly chatter between people who used the service and staff. One relative sat with their relative and assisted them to eat their meal. They also joined in the chatter which gave the dining room a lively but friendly feel, making lunch time a social event.

There was what was referred to as a,"Destination bar" where people who used the service and their visitors could help themselves to drinks and snacks.

Care plans contained details of the support people who used the service needed to ensure they ate and drank enough. The malnutrition universal screening tool (MUST) was used to assess whether or not a person was at risk of malnutrition. Where there were concerns about a person choking we saw that they had been assessed by speech and language therapists and the dietician had advised appropriate diets be put in place. Food and fluid charts were used to monitor people's daily food and fluid intake where there were concerns and monthly weights were completed to monitor weight loss or weight gain. This ensured that people received sufficient food and drink to maintain good health.

We saw that where people were unwell or had additional health needs, support was provided to access health care services. We saw evidence of visits by a GP, the speech and language therapist (SALT) and a dietician for one person. Care records contained details of people's health needs and contact information of any healthcare professionals involved in supporting them. Where someone who used the service was visited by a healthcare professional a record was kept of the consultation. These records showed that people who used the service were regularly seen by a wide range of healthcare professionals to promote and maintain their physical health and wellbeing.

Good

Is the service caring?

Our findings

We saw that most people who used the service were happy and one person told us, "I like it here" Two other people were sat together chatting in an animated fashion. A relative told us, "I've never heard people get cross with anyone. The staff are kind." However they went on to say, "My feelings are split; some days it is fantastic here but others I could pull my hair out. It is down to who is working."

Professionals told us that they had witnessed staff being caring. The district nurse told us, "Staff approach is very caring and they are considerate and kind to the residents" and a social worker said, "I have seen staff being kind and caring towards people."

We saw positive interactions between staff and people who used the service but in one case a member of staff had not considered how their behaviour may impact on people. At lunchtime the member of staff gave one person a drink and another their lunch without speaking to them demonstrating a task based approach rather than care being person centred. However, overall we noted that people were comfortable in the presence of staff and that staff were polite when they spoke to them. Their responses when spoken to and their body language suggested that they were relaxed around staff.

Staff told us that they believed care workers and other staff genuinely cared about people who lived at the home. One member of staff said, "We are like one big family" and another said, "If a member of staff is not right for the job, this would soon be picked up and dealt with." Others told us, "I do care and have a good relationship with people" and "I always speak to people with respect and at their pace." We observed one member of staff take time to update a relative about their mother's activities on the previous Sunday.

The registered manager told us in the PIR that staff were actively encouraged to be respectful and caring in their approach to the residents and their families. They told us that staff undertook person centred care and customer service training to ensure that they promoted the rights of residents and their loved ones. One relative told us, "I was involved by staff in the care planning and I attend reviews" demonstrating their involvement. In addition we noted that staff knocked on people's doors before entering.

On the ground floor notice boards there were activities for the day listed. The noticeboard also announced that a residents meeting was taking place that day with the activities co-ordinator. We did not see anyone from the first and second floors attend the meeting but we saw the activities organisers on day one of the inspection asking people what they would like to do on the first floor and on day two they provided distraction for one person who was distressed. This meant that people living with dementia had their wishes considered when deciding on activities.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010. In the care records we saw that people's needs had been addressed and the staff that we spoke with displayed knowledge and empathy in respect of people's needs.

There was no-one at the service receiving end of life care but training had been completed by staff to ensure they were competent when that should arise. All staff had completed training through the local hospice and three champions in palliative and end of life care had been appointed; one to each floor of the service. They were able to liaise with a link clinical nurse specialist at the hospice for advice and guidance. This meant that when people reached the end stage of their life there were suitably qualified and well supported staff available to care for them. The clinical nurse specialist from the hospice told us, "Staff are always really attentive to people's needs. Really good with documenting end of life wishes and all DNACPR forms are in place appropriately. They have engaged with the palliative care support offered and involve new staff." DNACPR(Do Not Attempt Cardiopulmonary Resuscitation) forms are forms used to record people's wishes about resuscitation.

We saw that staff encouraged people to be as independent as possible and only assisted them with the things they found difficult or could not achieve.

Good

Is the service responsive?

Our findings

Some of the people who used the service told us that staff were responsive to their needs. Others were living with dementia and were not able to clearly communicate their thoughts and so their relatives responded. These responses were mixed. They told us, "Everything here depends on who is working." "If we ask some staff to do things it happens but with others it doesn't" and ""They are very good with her."

Professional's feedback was more positive and they reported seeing good personalised care when they visited the service. The clinical nurse specialist told us, "They [Staff] can always tell me about people's individual needs, so they know the people there well" and the social worker said, "On the first floor the home has people with quite complex needs and some advanced dementia and they manage the needs of these people well. They follow the guidance given to them by professionals, including the mental health team." Although there were some inconsistencies to the responses our own observations led us to determine that overall staff were responsive to people's needs.

Each person who used the service had a care record which outlined their needs and any associated risks. The care plans were in the form of a narrative which was easy to read so that staff could easily access the information needed to provide appropriate care for people. We reviewed nine peoples care records and saw they were person centred and identified any areas of risk for that person.

Risks were clearly identified and management plans put in place. One person was at risk following weight loss. Staff had started food and fluid charts, were giving smaller meals and finger foods to tempt them to eat and maintain food intake. The person had been referred to the dietician through their GP. Another person was identified as being able to make some decisions and the instruction for staff was to, "Allow [name] to continue to make decisions to remain happy." People had given their consent for personal care to be provided and had agreed that their records could be shared with other professionals if it was necessary.

Care files contained a 'My Life Story' which gave detailed information about people's lives, their likes, dislikes, preferences, work history and any activities they enjoyed. The record also identified who was important to them. This showed us that people who used the service and their relatives or friends were involved in care planning. A relative of someone who used the service told us. "I was involved in his care planning." Other relatives also told us that they were involved in care planning and review meetings.

We saw that care files were reviewed and updated regularly to ensure that they contained relevant information as people's needs changed. We saw that a daily handover record was maintained to share important information about people's needs, changes and any significant events that had occurred from one shift to the next. This was designed to ensure staff had up-to-date information and supported staff in meeting people's changing needs.

The registered provider employed three fulltime and one part time activities coordinator to take the lead on organising activities within the service. They provided details about the activities on offer and we could see these advertised in the reception area. These included music, exercise, a knitting club, baking and one to

one activities. We saw that staff invited people to take part in activities, but respected people's choices where they did not want to join in.

We observed the activities during our inspection and saw that people who used the service were supported to do arts and crafts and other activities. During the inspection we saw people drawing and painting calmly and enjoying interaction, listening to 1950s music, singing and talking with one another. On the ground floor a person was booked to play the piano.

Alongside the daily activities organised by the service we also saw that people had their own interests. On the first floor we saw one person on their own computer in their room playing a game. We were also told that the service had a chalet in the North Bay of Scarborough for people to visit in groups in good weather. In order that staff can meet people's needs whilst at the chalet the service had a stock of games and equipment so that people could, "Make a day of it." The activities co-ordinators took people out for walks in the garden and into the community. A visitor told us, "He [Friend] goes out sometimes. He has been out for tea."

There was a hairdressing service on four days of the week. This was a permanent and busy service. The hairdresser told us, "This is the best job I have ever had. People know me and we have lovely one to one conversations. People come in for a sit down and a chat."

We observed a meeting between people who used the service and the activities co-ordinator. The activities co-ordinator asked people what they would like to do as part of the activities programme and if there were places they would like to visit. They noted everyone's ideas making this a positive meeting.

We saw that people's relatives and friends visited the home throughout our inspection and staff were warm and welcoming towards them. One relative of someone who used the service said, "I can help myself to a drink when I visit." In the destination lounge there was a computer that people could use to 'Skype' their relatives. Skype is an internet communication service. In addition there was a reminiscence sheet called 'Daily Sparkle'. This contained articles about the way we were and had 'Do you remember' sections. This was pictorial and interactive making it suitable for everyone at the service. This showed us that staff supported people who used the service to maintain important family relationships.

Complaints were managed according to the service policy and procedure. The registered provider had a policy and procedure in place which recorded how they would deal with complaints about the service. People were given details of how to complain when they arrived at the service. The registered manager told us in the provider information return that they had received four formal complaints in the last twelve months. We discussed these with the registered manager and saw evidence of the complaints being recorded and the registered manager's responses. The registered manager was able to tell us the circumstances of the complaints and any actions taken.

Good

Is the service well-led?

Our findings

At the time of this inspection there was a manager employed who was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration. The registered provider had five key values around placing people at the heart of care, honesty and looking to improve which gave structure to the registered managers work in the service.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had made notifications as required. They had informed CQC of all other significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely in accordance with the requirements of the Data Protection Act.

People who lived at the home and relatives knew who the registered manager was. The registered manager told us that they walked around the service several times a day making themselves available to speak with people.

Staff told us that there was good management and leadership at the home. One member of staff said, "[Name of registered manager] is very approachable. I could go to them for advice and they would support me. "Staff told us they would use the whistle blowing procedure if they needed to, and were confident the registered manager would protect their confidentiality.

We saw that there was a quality assurance system in place that included surveys, audits and meetings. Audits were carried out six monthly and covered the whole service. In addition, each month care plans were audited and the registered manager did a themed audit in areas such as catering, infection control and medication. A company auditor visited the service annually. We saw that audits were sent to the company head office where they were analysed them and any shortfalls highlighted in a corrective action plan which was sent back to the registered manager. The registered manager told us that, if any urgent shortfalls were identified, these were dealt with immediately.

Feedback was collected from people who were involved with this service. A satisfaction survey had been distributed to people who use service, relatives, and staff. People's comments were compiled and analysed by the registered manager and the area manager and an action plan drawn up. The latest survey resulted in 27 sets of feedback being returned which equated to a 40% return rate. Relatives were also encouraged to comment directly to the registered manager in her office or by email or phone.

Staff meetings were held on a monthly basis. There were meetings for specific groups of staff such as night staff, cooks and housekeepers. The minutes of these meetings showed a variety of subjects relating to working at the service had been discussed. These minutes were signed and dated. This ensured that all staff

were aware of the topics discussed and the decisions made. Staff told us that these were 'two-way' meetings where they could express their views. One member of staff said, "We are encouraged to ask questions and discuss work related areas."

Relatives meetings were planned for the month following our inspection. The registered manager told us that individual meetings were held on each floor. There had been no other recent relatives meetings which meant that there were no opportunities for the relatives to come together as a group and discuss any positive or negative experiences. These meetings would have provided an opportunity for families to discuss the concerns they raised with us, such as the inconsistency of staff approach and communication.

Meetings for people who used the service took place periodically with the activities organisers and one took place during the inspection. Previous meetings recorded areas such as food, activities, and outings as being discussed. It was not clear how the views of people living with dementia had been sought including through non-verbal communication and visual cues where this may have been more appropriate.

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The registered manager kept up to date with best practice through attendance at Independent Care Group meetings. The Independent Care Group (ICG) is a local representative body for independent care providers. They also attended management training provided by the provider.

The service is part of a Urinary Tract Infection (UTI) working group, which is attended by the infection control nurse and professionals from the local clinical commissioning group (CCG). The registered manager told us they were planning to explore catheter care training after a concern raised led to them reassessing staff skill levels in this area. The registered manager is also involved in a Norovirus working group led by the CCG. This demonstrated their commitment to improving services for people.