Cuerden Developments Limited

Cuerden Developments Limited - Appleby Court

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The unannounced inspection took place on 19 February 2015. At the last inspection in July 2014 the service was found to be non-compliant with regard to staffing levels at night time on the two nursing units. Some improvements have been made to by the service to reduce the length of the night time medicine round so that staff have more time to attend to the needs of the people who use the service.

Appleby Court Care Home is a purpose built, two storey care home which provides both nursing and residential care for a maximum of 81 people. At the time of the inspection there were 74 people using the service.

There was a registered manager, who was not present on the day of the inspection. A registered manager is a person who has registered with the Care Quality

Summary of findings

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.

There were robust medication systems in place for administration, storage and disposal of medicines in place.

However, we found that there was still a concern about the length of the night time medication round on the nursing units. This was due to the round taking a significant length of time to complete and only one qualified nurse on shift to administer the medicines. Although this was not currently having a significant impact on people who used the service, we found that people were not always getting their medicines at night in a timely way. We have made a recommendation about consulting current best practice guidance around medication administration.

People who used the service told us they felt safe and secure and sufficient staff were in place on the day of the visit to administer care safely. Appropriate health and safety and emergency contingency plans were in place.

The home had robust recruitment procedures for new staff. This included, taking up two references, an application form, obtaining proof of identity and undertaking Disclosure and Barring Service (DBS) checks to ensure staff were suitable to work with vulnerable people.

Policies and procedures for safeguarding vulnerable adults were in place and staff demonstrated a good understanding of safeguarding issues.

People reported that the food at the home was good and that changes to the menus had been made in response to their suggestions. We saw that a choice of meals was offered and people were given sufficient drinks throughout the day.

We looked at seven care files and found they included a range of personal and health information and were complete and up to date. We saw that care files were person centred and met people's individual needs and preferences. People were able to access services from other agencies and professionals whenever this was required.

Although there was little evidence of written consent within the care plans there were references to staff obtaining consent within each part of the files. The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Staff induction was robust and included mandatory training, shadowing and competency assessment. Staff training was comprehensive and on-going.

We observed staff throughout the day interacting with people in a respectful and courteous way. We saw that staff made efforts to preserve people's dignity and privacy when offering assistance.

Information was given to people who were thinking of using the service and their relatives in the form of a service user guide, which was a leaflet that gave some details about the service. Each person who used the service had a service user guide in their bedrooms.

Residents' and relatives' meetings were held regularly, approximately six to eight weekly, to ensure people had a forum to raise concerns and put forward suggestions.

The home made efforts to ensure that people's choices for end of life care were respected.

We saw the activities timetable which advertised a number of activities. People told us there were many events and activities which took place within the home on a regular basis.

There was an up to date complaints policy which was outlined in the service user guide of which each person who used the service had a copy. We saw the complaints log and this evidenced that complaints were followed up appropriately.

We were told by people who used the service that they felt the registered manager was approachable.

Staff said they felt well supported in their roles and supervisions and appraisals were undertaken on a regular basis. Staff meetings were also regularly held, ensuring staff had a forum to raise concerns and discuss issues.

A number of audits and quality checks were carried out at the home to ensure quality was monitored and improvements made on an on-going basis.

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?

Requires Improvement

The service was not always safe.

People on the two nursing units were not always getting their medicines at night in a timely way.

Robust medication systems for administration, storage and disposal of medicines were in place.

People who used the service told us they felt safe and secure. Sufficient staff were in place on the day of the visit to administer care safely.

Appropriate health and safety and emergency measures were in place.

Robust recruitment procedures were in evidence at the home.

Policies and procedures for safeguarding vulnerable adults were in place and staff demonstrated a good understanding of safeguarding issues.

Is the service effective?

Good

The service was effective.

People reported that the food was good and that changes had been made in response to their suggestions. We saw that a choice of meals was offered and people were given sufficient drinks throughout the day.

Care files included a range of personal and health information and were complete and up to date. People were able to access services from other agencies and professionals whenever this was required.

Although there was little evidence of written consent within the care plans there were references to staff obtaining consent within each part of the files.

The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Induction of new staff was robust and staff training was comprehensive and on-going.

Is the service caring?

Good

The service was caring.

We observed staff interacting in a respectful and courteous way throughout the day, ensuring they preserved people's dignity and privacy.

Information was given to people who were thinking of using the service and their relatives.

Residents' and relatives' meetings were held regularly to ensure people had a forum to raise concerns and put forward suggestions.

Summary of findings

The home made efforts to ensure that people's choices for end of life care were respected.

Is the service responsive?

Good

The service was responsive.

We saw evidence of a number of activities which took place within the home on a regular basis and people who used the service said there was plenty to occupy them.

We saw that care files included a range of personal information and were person centred and individual.

The complaints policy was outlined within the service user guide and each person who used the service had a copy. We saw that complaints were followed up appropriately and people reported they would feel confident to report any concerns.

Is the service well-led?

Good

The service was well-led.

People who used the service told us they felt the registered manager was approachable.

Staff said they felt well supported in their jobs and undertook supervisions and appraisals on a regular basis.

Regular staff meetings were held where staff had the opportunity to discuss issues and concerns.

A number of audits and quality checks were carried out at the home to ensure quality was monitored and improvements made on an on-going basis.

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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 was unannounced and took place on 19 February 2015. The inspection team consisted of a CQC adult social care inspector 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.

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 improvements they plan to make. We also reviewed information we held about the home in the form of notifications received from the service.

Before our inspection we contacted Wigan local authority quality performance team, who visit the service regularly, to find out if they had any concerns about the service. We also contacted the local Healthwatch to see if they had any information about the service. Healthwatch England is the national consumer champion in health and care.

One the day of the inspection we spoke with nine people who used the service, two relatives, one professional visitor and six members of staff, including the chef, the administrator, two care staff and two nurses. We looked at records held by the service, including seven care plans, two staff files, minutes of residents' and relatives' meetings, minutes of staff meetings, training records and audits.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

The service had previously been judged as non-compliant around staffing levels because there was only one qualified staff member on duty overnight to oversee both nursing units. The medicine rounds at night, for both nursing units, took approximately three hours to complete. Since then the management had made some changes to the medicine rounds to cut down the time they took, such as the percutaneous endoscopic gastrostomy (PEG) feeds now being carried out by day staff. There was no problem on the residential units as there were two senior staff members who dealt with medicine administration.

We spoke with five staff members about this. The nursing staff we spoke with said they had no concerns about the length of the medication rounds. However, they explained that, although the medicine rounds were now shorter they still took a considerable length of time, possibly two to three hours, to complete. This resulted in some people who used the service having to be woken to take their medicines, or the nurse making a judgement on whether the medicine was necessary or could be missed.

We spoke with nine people who used the service about how their medicines were administered, but none had any complaints about the timings of their medicines at night time. One person told us, "I get my medication on time, I have twelve tablets in the morning with my breakfast and if I have any pain I can get painkillers. If I have a pain at night I buzz them and they will bring me some painkillers". Another person told us, "I get my medication on time; in fact they have just been in to give it to me". A third person commented, "The district nurse comes in and gives me an injection three times a day, at breakfast dinner and tea time. I generally get them when I should but occasionally they are very busy and the time can slip a bit".

Although there were no complaints about night staffing levels by people we spoke with who used the service, the night time medication round was still taking a significant length of time to complete on the two nursing units. The fact that some people may have to be woken for their medication, or a judgement be made whether they could safely miss the medication, was not good practice. There could also be adverse effects to people if their medicines were given with too little time in between, due to the length of the round.

We recommend that the service consider current best practice guidance on administering medication.

We asked people who used the service whether they felt there were enough staff at the home. One person said, "They know when I want them and they are there more or less all the time. Occasionally I use the buzzer and they come quickly enough". Another told us, "The staff here work really hard and I think they could do with one or two more on the floor. If I press the buzzer, they are here straight away, but if three or four are buzzing at the same time they can't do everything at once. Sometimes at night there is only one senior nurse for upstairs and downstairs. I think there should be one for upstairs and one for downstairs".

We observed the numbers of staff on duty on the day of the visit and saw there were sufficient to meet the needs of the people who used the service. We looked at staffing rotas and these evidenced that there were enough staff on duty each day and that agency staff were only occasionally used to cover for sickness or annual leave. The service only used agency staff if there were no regular staff available and they endeavoured to use the same agency staff as much as possible so that they would be familiar with the home, the routines and the people who used the service. The nurse in charge on the day told us that the senior on each shift would decide how to deploy the staff to ensure their best use.

We spoke with nine people who used the service. When asked if they felt safe, one person said, "I do feel safe here". Another told us, "Yes, I feel safe here", and a third commented, "I think I am content and safe here".

We spoke with three relatives about how safe their relatives were. One relative told us, "I'm very happy with the care here, my [relative] is in a safe place where she is well looked after". Another relative told us, "I'm happy with the way they look after my [relative]; I have no worries about their safety". Another relative told us, "There are enough staff here to look after my [relative] properly".

We looked at two staff personnel files. They contained evidence of safe recruitment, including an application form, interview notes, two references and proof of identity and employment contracts. Each staff member had a Disclosure and Barring Service (DBS) check, which helped ensure people were suitable to work with vulnerable people.

Requires Improvement

Is the service safe?

There were appropriate health and safety and fire safety policies held by the service and fire equipment and signage were visible around the home. We saw written evidence that weekly fire alarm tests were carried out. Window restrictors were in place and window checks undertaken every evening to help ensure people's safety.

Emergency contingency plans were in place, in a file in the main office. They included contact numbers for relevant services, information about all the electrical appliances in the home and next of kin details for every person who used the service. There was a file with personal emergency evacuation plans (PEEPS) for each person. These detailed the level of assistance that would be required by the people who used the service in the event of an emergency.

The home had policies in place around whistle blowing, bullying and harassment, vulnerable adults abuse and lone working, which were updated regularly. Signatures of staff had been obtained to confirm that they had read these policies. The safeguarding policy included relevant contact numbers and guidance around reporting concerns. We saw from minutes that safeguarding and whistle blowing had been discussed at team meetings to help keep staff's knowledge current and up to date.

We had reviewed notifications and information we held prior to the inspection and these evidenced that the service reported safeguarding incidents appropriately. We spoke with five staff members who all demonstrated a good understanding of safeguarding issues, had undertaken appropriate training and were confident about the reporting procedures.

We saw the home's medication policies, which were appropriate and up to date and included guidance on medicines for occasional use. There was a policy with regard to homely remedies and a book where administration of these was recorded.

The nurse on duty told us that only qualified staff, nurses on the nursing units and senior carers on the residential units, were trained and, when assessed as competent, allowed to administer medicines. One of the nurses showed us the systems which were used for the ordering, storing and disposal of medicines. These were robust and effective systems. Requests for new medicines or prescriptions were double checked to ensure safety. Controlled drugs were stored in a locked cupboard, within a locked room and records signed by two people to help ensure safe administration.

We observed one of the nurses administering medicines at lunch time. We saw that she checked the Medication Administration Record (MAR) sheets, each of which had a photograph of the person who used the service, to ensure she was giving the correct medicine to the right person. The medicines were only signed for when the nurse had observed that person take them and any refusals were documented.

Each person's medicine was taken from a blister pack and placed in an individual pot, then taken to the person and the nurse watched them take the medicine. PRN medicine, that is medicine to be taken as and when required, was offered to those people it was prescribed for and they were asked if they wished to take it. Some medicines were given with thickened fluid, rather than water, for those who may experience swallowing difficulties. The nurse ensured the liquid was the correct consistency for each person.

Good

Is the service effective?

Our findings

We asked people who used the service whether the food at the home was good. One person said, "The food is very good". Another told us, "The food is good, I don't usually go to the dining room for my meals, I prefer to eat alone. The staff will help me with my food if I need it, it depends what it is and what I can see. I have macular degeneration you see". A third person told us "The food is good, generally I have my meals in the dining room, I like to keep moving if I can. There's a good choice of food and they come the night before and ask you what you want from the menu or you can have sandwiches if you want". A fourth person commented, "The food is fine, I have no grumbles about the food. I usually take what's on the menu when they ask me what I want to eat. Mostly they [the staff] fetch it to my room but sometimes I go to the dining room to eat it".

Food had been discussed at a recent residents' meeting and people who used the service told us changes had been made to the type of food offered, so that all the food was now prepared from basic ingredients in the kitchen rather than bought pre-prepared and the main meal was now served in the evening rather than at lunchtime to suit the preferences of the people who used the service. One person told us, "I've brought up the meals at the meetings. Old people don't want sandwiches every day, they want things like hot soup. The meals have got better over the past few months. If I don't like anything I tell them and the give me a choice of something else".

The chef, who was newly appointed and was responsible for the preparation of food in Appleby Court and the neighbouring Berkely Court next door, confirmed that all the meals were prepared from basic ingredients on a four weekly rotating menu. The menu was designed following consultation with the people who used the service and the kitchen had records containing the likes and dislikes of individuals in addition to the needs of those on special diets. Pureed food was served from the same menu, with individual parts of the meal pureed separately so that people could identify different textures and tastes..

Various special diets were catered for, including high calorie, diabetic, vegetarian, allergy specific and nut and gluten-free. The individual meals were plated by the care staff serving in the dining room, or served to the individual in their own room and the care staff had their own list of which people required a special diet or who preferred small or large portions.

The kitchen currently had an environmental health rating of two stars due to the need to upgrade some kitchen equipment and the need to replace some tiles that were broken at the time of the last inspection. These issues had since been addressed and the chef expected the rating to improve following the next inspection.

During the inspection a lunchtime meal in the dining room of the ground floor residential wing was observed. Eleven people who used the service were served by three staff between 12.30 and 1.30 pm. The meal consisted of beef and tomato soup, baked potato with cheese and yoghurt. For those that did not want a baked potato there was a choice of chicken, beef, ham, or egg sandwiches. All individuals were able to eat without assistance, only three people needing protective aprons and five people needed help with escorting into and out of the dining room. The meal was conducted in a calm and relaxed atmosphere with quiet conversations taking place between the people who used the service on each table.

People were asked what size portion they wanted and some were encouraged to eat. People were offered a choice of hot drink either tea or coffee and milk or sugar to taste. People were asked if they wanted more of each course before their plates were removed by the staff. People were able to change their minds about choices made and were served their final preference with politeness. Staff spoke with respect and courtesy to the people who used the service throughout the meal, with frequent use of "please" and "thank you" in their exchanges. When people were assisted from the dining room they were asked where they wanted to go.

We looked at seven care files for people who used the service. They included a range of health and personal information. The files included risk assessments, which were reviewed and updated on a monthly basis. There were also monitoring charts around issues such as weight management, nutrition and falls. These were complete and up to date for six people and the care plans in the seventh file were in the process of being rewritten by the nurse in charge at the time of the inspection.

Good

Is the service effective?

We saw evidence in the records that people who used the service and their relatives had been involved in the writing and reviewing of their care files. However, although it was clear that the person who used the service had been involved in discussions, most care plans had been signed by relatives rather than the person who used the service. We spoke with one of the nurses who told us that it had been the home's practice to ask a relative to sign the care plans. She agreed that the person who used the service should be asked to sign the records in future, if they were able to do so, and if not, a reason for this should be recorded.

We did not see written consent forms within care files, for example, for the service to use the person's photograph on the file and for other purposes. However, we saw some excellent examples in the care plans of guidance for staff about the need to gain consent for all interventions, for example, with bathing or showering or personal care. The need to ensure that the person consented to care and treatment was referred to within all care plans relating to care interventions in each care file. We also observed verbal consent being sought from people who used the service by staff throughout the day for all interventions, including offering food, assisting people to the toilet, offering medicines.

People who used the service and their relatives reported that they were able to access health and medical assistance when they needed it. One person said, "The doctor has been to see me. If I need to see him, the staff phone him and he comes". Another commented, "If I need to see the doctor I mention it to the nurses and they arrange for him to visit. I've seen him about five or six times in the past few months". A third person told us," I had a pain in my leg, they phoned the doctor and he came out that evening, they do get medical help out straight away if there is anything wrong". This was confirmed by the care plans we looked at where professional visits, advice and discussions were recorded. Each care plan contained a hospital transfer form which included information which would be required on admission, such as current medication and health conditions.

We looked for evidence that the service was working within the requirements of the Mental Capacity Act (2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA sets out the legal requirements and guidance around how to ascertain people's capacity to make particular decisions at certain times; DoLS is used when a person needs to be deprived of their liberty in their own best interests. This can be due to a lack of insight in to their condition or the risks involved in the event of the individual leaving the home.

There were mental capacity assessments in place for issues such as the use of bed rails to prevent the person who used the service from falling out of bed. We saw one such assessment around the use of a wheelchair and lap belt. There was guidance included, instructing staff to explain why the lap belt was being used, even if the person did not appear to understand. We also saw records in the files which stated that people who used the service should be assisted and supported to make own decisions, indicating a good understanding of the principles of the MCA. We saw references within care plans to people's rights to make unwise decisions if they had the capacity to do so.

We saw records of restrictive practice which were reviewed on a monthly basis. These were up to date and we saw that changes and updates had been made to the records appropriately. The restrictive practice records included consideration of how to minimise the restrictions without putting the person at undue risk, which again indicated a good understanding of MCA principles.

There was a policy and procedure regarding MCA and DoLS but this was due to be reviewed and updated as the review date for the policy had recently passed. There were six people who used the service currently subject to DoLS authorisations and all the relevant paperwork was in the care files and was in order. Conditions to the authorisations were clearly recorded within the care plans to ensure staff were aware of these.

We spoke with five members of staff and they all demonstrated a thorough understanding of the MCA, including how to support someone with the decision making process. However, some of the carers had only a basic knowledge of DoLS and were unaware of how a DoLS authorisation could impact on the day to day care delivery.

We saw that the home had staff members who were champions in particular fields, such as dignity and tissue viability. Champions in infection control were to be identified in the near future. These staff members had received extra training in the fields they specialised in and took the lead in ensuring they kept up to date with changes, training and disseminating information to other staff.

Good

Is the service effective?

Evidence of a robust induction procedure was seen in two staff personnel files we looked at. We saw that the company used the skills for care induction for all new employees. This included mandatory training and checks throughout the induction process to ensure the person had understood what they had read and learned and could demonstrate competency. Staff told us they shadowed more experienced staff until they were confident to carry out their care duties alone. There was also evidence of regular supervision sessions and yearly appraisals within the staff files.

We spoke with five members of staff who all told us that there were lots of opportunities to access training. They told us their knowledge and learning was kept up to date with training on offer. This was confirmed by the training matrix and we saw that the service's administrator checked the matrix on a monthly basis to ensure staff training was kept up to date. Any refresher training that was due was flagged up and this was then booked and the staff member informed that they needed to undertake the training.

Good

Is the service caring?

Our findings

We spoke with nine people who used the service, who all said they were treated with dignity and respect and were aware of the home's key worker system. This is a system where a particular member of staff is identified as the main contact for the person and their family. One person told us, "The staff are all very nice, they look after me properly, they all know I can't see and they are always explaining what they are doing when they help me. They are probably doing more for me now than they used to". Another said, "The staff come and talk to me, they can't do any more for me. They respect my privacy and always knock before they come in and always ask if I want my door open or closed when they leave. I'm quite content, well fed and anything I ask for they will get for me". A third person said, "The staff are all nice people, different people come at different times. I have enough privacy, my door is usually open, but I can have it closed if I want".

We asked about visiting and one person told us, "My family can visit when they like". Another commented, "My relatives live in London, but when they are up here they can visit when they wish". One relative told us, "We can visit anytime; [my relative] usually gets someone coming every day to spend time with them". Another said, "I can just walk in and out and there's no problem".

We observed care and interactions between staff and people who used the service throughout the day. The atmosphere in the home was calm and relaxed with staff going about their work with quiet efficiency and respect for the people who used the service. It was common throughout the day to hear staff using "please" and "thank you" in their exchanges with people who used the service. We saw that staff took time to give explanations about what they were offering to assist the person with. We heard staff asking people's permission to help with personal care tasks and, if the person refused, they tried gentle persuasion or went away and came back later to offer help again.

We saw that initial information was given out to people who may wish to use the service and their relatives, in the form of a service user guide, which included the core values, care objectives, information about activities, visiting, security, meals, services and complaints. A service user guide was also in each person's bedroom for them or their relatives to consult at any time.

There was a monthly newsletter produced by the home to keep people up to date with forthcoming events and report on what had happened during the previous month. There were also activities in the newsletter, such as spot the difference pictures and tongue twisters. One person who used the service commented, "I get the monthly newsletter, my niece usually gets it from the foyer. It's good to know what's going on".

Residents' and relatives' meetings were held on a three monthly basis, where people were able to raise any concerns or put suggestions forward. We asked people how they felt about these meetings. One person told us, "I've been to a few of the meetings they have here. I think they are a good thing". Another said, "Yes I've been to the meetings, when they call us in to go. We all meet together and talk things over and the manager sees what she can do about them". A third person said, "I've not been to the meetings but I know they go on. I have seen the newsletter and I get to know what's going on". A fourth person told us, "What was said at the meeting about the food has improved things".

We looked at care plans for seven people. We saw that there were references to dignity and privacy, instructing staff to be discreet when offering personal care interventions and reminding staff to ensure the person had privacy. We saw staff knock on people's doors and wait to be asked to enter if people were in their own bedrooms. There was a dignity champion at the home who was the lead person in this field and ensured new information was disseminated, knowledge was current and training up to date.

We saw appropriate policies and guidance around issues such as care and welfare, ageing and death, confidentiality, diversity in care, protecting residents' rights, dementia, end of life care.

The nurse in charge on the day told us that the local end of life care team attended the home when people needed them and this was evidenced within some people's care files. This helped ensure people could have the choice to stay at home at the end stages of their life. There was an end of life care champion at the home to help coordinate this joined up care.

Good

Is the service responsive?

Our findings

People who used the service that we spoke with reported that there was enough going on in the home to stimulate and occupy them. One person said "I spend most of my time in my room either reading or watching TV". Another told us, "I usually stay in here unless my family come and take me out. They have a bit of a concert on Thursdays, I went and enjoyed it, I can only hear and can't see pictures but I can still join in". Another person who used the service commented, " We all go to the day room for some recreation. I do exercises when I get up in a morning and they have things going on in the day room, we watch TV, or have a chat amongst ourselves". A fourth person told us, "I enjoy my jigsaw puzzles and we have a reminiscence day on Thursdays and bingo on Fridays".

One relative said " There seems to be a lot of activities going on here for those that want it. There's photos of events and things in the newsletter".

We saw the activities timetable for the week and this included manicures, tubs (from which people who used the service could choose games to be played), baking, quizzes, sensory experiences, storytelling, trips to the local shops, bingo and balloon tennis and reminiscence. We saw that communion services were held regularly to facilitate some people's spiritual requirements. The activities coordinator did not stick to a programme of activities but told us some of the activities were fluid and changed on a weekly basis as a response to people's preferences.

We observed the reminiscence activity which took place on the day of our visit in the reminiscence area. This part of the home was decorated with old pictures of the area and objects from the past, such as oxo tins, match boxes and stamps. The activity was facilitated by a volunteer and the activities coordinator for the home assisted by bringing people to the reminiscence area, encouraging them to join in and ensuring that everyone was enjoying themselves. This event was very popular and a significant number of people who used the service attended. There was a lively atmosphere and people joined in with the singing or by clapping along to the music. Buns and cream, sweets and drinks were offered to the people who participated in the activity, which they all said they enjoyed.

We looked at care files for seven people and saw that they included personal information and reference to preferences and choices. For example, people's preferred rising and retiring times were recorded. We saw that care plans were individual and person centred, some including guidance for staff on how to deal with behaviour that may challenge the service, some made reference to the person's need for lots of reassurance and encouragement or their particular strengths, worries and difficulties. One care plan advised staff to be aware of the person's body language in order to deliver the best care.

We asked people who used the service if they could exercise choice around daily living tasks. One person told us, "They usually ask when I want to go to bed and when I want to get up and get dressed". Another told us, "I'm not one for lying in bed and they ask me if I want to get up and dressed if they find me awake, even at 6.30 am". A third person told us, "You can stay in bed in the morning if you want to, I can get a bath when I want one". We saw that people's bedroom doors were sometimes open and sometimes closed. People who used the service told us they chose how they wanted their doors to be.

The service had an up to date complaints policy. This included information about other agencies which could be accessed if the complaint was not satisfactorily dealt with by the home. The complaints procedure was outlined within the service user guide, given to each new user of the service and their relatives. There were complaints forms in the reception area and a box to place them in, if people wished to do that.

The people who used the service that we spoke with said they had no complaints and would know who to speak to if they were worried about anything. One person said, "I have had no concerns or worries whilst I have been here, I would speak to the nurse in charge if I did". Another told us "I have no complaints and I would pretty quickly speak to the people in the office if I did. I think they are approachable and they know me by now".

Good

Is the service well-led?

Our findings

We asked people who used the service if they felt the registered manager of the service was approachable. One person said, “She makes the care home a proper home, she said to me ‘if you have any trouble you come to me’. I‘ve seen her at the meetings and we get on OK”. Another person said, “She is a nice girl, they are all very nice, I would talk to her if things weren’t right”. A third person told us, “If I had any worries I would talk to those in the office, I think they are approachable and would listen”.

We spoke with five members of staff, all of whom told us they felt well supported by the registered manager of the service. They told us they had regular supervisions and appraisals and they felt this helped with their professional development. The staff we spoke with demonstrated a good understanding of their roles and responsibilities.

We spent some time in the main office and observed staff coming in and out throughout the day and interacting well with each other at all levels. We observed senior staff making telephone calls to other professionals, such as GPs, to discuss people’s care needs. We saw that they made efforts to ensure care was joined up for people.

The home had recently been involved in a safeguarding investigation and we saw, via observation and through records, that their involvement had been appropriate and their investigations thorough. The registered manager had followed the home’s own procedures and the processes set out by the local authority and the matter had been dealt with in a timely manner, demonstrating good partnership working with other agencies.

We saw that accidents and incidents were appropriately recorded. These were audited on a monthly basis and analysed for patterns or trends. If any pattern was identified, prompt action was taken to attempt to minimise any further risk.

Regular staff meetings were held with the various different staff groups. This was a forum where staff had the opportunity to discuss issues and raise concerns. We saw minutes of the most recent staff meetings.

The training matrix was checked on a monthly basis to ensure all staff were up to date with their training needs. When refresher courses were due these were flagged up on the system and followed up with staff by the administrator. The registered manager had oversight of the system to ensure she was aware of the training undertaken and further training needs of all staff.

We saw evidence of a number of two monthly audits relating to areas including infection control, medication, laundry, catering, cleaning, maintenance, fire equipment and health and safety. We saw that issues were identified and actions documented. Some daily checks were also carried out, for example, environmental checks, to help ensure people were kept safe.