Ferrolake Limited

Westport Care Centre

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

We inspected Westport Care Centre on 9 and 10 May 2016, the inspection was unannounced. Our last inspection took place on 4 June 2013 and we found that the provider was meeting all of the regulations that we checked.

Westport Care Centre is a residential care home and provides personal care and dementia care for 42 older people. The home is a large detached building and the accommodation is set out over four floors. All the bedrooms have en-suite bathrooms in addition to shared bathrooms. There was a large garden and comfortable lounge areas.

The service had a registered manager. 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 a good understanding of the safeguarding procedures and followed protection plans to minimise the risk of harm to people. Prevention measures had been put in place to minimise future re-occurrences of any incidents.

Thorough recruitment checks were completed to assess the suitability of the staff employed.

The home had good infection control measures in place. Regular testing and servicing of equipment was carried out.

People's medicines were managed safely by trained staff. There was a robust procedure in place for the administration, storage and disposal of medicines.

People were supported to eat a well-balanced diet and their nutritional and hydration needs were met.

Staff received training that was reflective of the needs of the people who used the service.

Consent to care and treatment was sought in line with relevant legislation and guidance on best practice. People had access to healthcare and had no difficulty accessing support with their health care needs.

The provider held 'my special days', to help best understand how the staff could meet people's wishes.

People were included in specific activities to help reduce social isolation and loneliness.

The registered manager promoted a work culture that was family orientated and that put people first. Relatives and people spoke positively about staff that supported them in the home.

Relatives' discussions were held and people were informed of changes to the service, people's views were sought on how their care should be delivered.

The service benchmarked best practice to review the delivery of care against current guidance. Complaints had been responded to appropriately when they were raised.

We have made a recommendation about recording person centred care in people's care records.

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.

Potential risks to people's health and wellbeing were identified and managed effectively.

Sufficient numbers of suitable staff were available to meet people's needs at all times.

Safe and effective recruitment practices were followed by the provider.

People were supported to take their medicines safely by trained staff.

Is the service effective?

Good

The service was effective.

People were supported to eat a well-balanced diet and their nutritional and hydration needs were met.

Staff were well trained and supported by the provider to help them meet people's needs safely and effectively.

Consent to care and treatment was sought in line with relevant legislation and guidance on best practice.

People's day-to-day health needs were met and they had access to health and social care professionals when necessary.

Is the service caring?

Good

The service was caring.

People told us staff were considerate and caring, and their privacy was respected.

People were encouraged to maintain positive relationships with family, friends and staff.

Staff knew people well and had a good understanding of their

personal histories and preferences.

Is the service responsive?

Good

The service was responsive.

The provider held 'my special days', to help best understand how the staff could meet people's wishes.

People were included in specific activities to reduce social isolation and loneliness.

People understood how to raise complaints. Concerns were actioned and responded to in a timely manner.

Is the service well-led?

Good

The service was well led.

The registered manager promoted a work culture that was family orientated and that put people first.

Staff spoke positively about the registered manager and how they promoted choice and independence for all people within the home.

The provider sought the views of the people using the service and their relatives to ensure that improvements were made where required.

Records were regularly audited and the provider measured and reviewed the delivery of care against current guidance.

Westport Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 10 May 2016 and was unannounced. The inspection team consisted of one inspector, a specialist advisor who is a registered nurse and two experts by experience on the first day and one inspector on the second day. 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 us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the PIR, previous inspection reports and notifications sent to CQC by the provider. The notifications provided us with information about changes to the service and any significant concerns reported by the provider. We also contacted the local authority and looked at the information they sent us about the service.

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.

We spoke with 16 people who used the service, two relatives and two district nurses who were visiting people on the day of our inspection. We spent time observing the care people received and activities they attended in the home and toured the building.

We spoke with two senior team leaders, two team leaders, four care workers, the administrator, housekeeper, kitchen assistant, cook, domestic staff, maintenance worker, the regional manager and the registered manager. We looked at the records in relation to eight people's care including their medicines records. We also looked at six staff recruitment and training records, minutes of meetings with staff, quality assurance audits, complaints, staff rotas and some of the provider's policies and procedures.

Good

Is the service safe?

Our findings

We asked people who lived in the home if they felt safe and comfortable. One person told us, "Any member of staff, they are all helpers, they're very good here." Another person we spoke to said, "Yes, we get some very good staff here, that's why I feel safe." Relatives explained they had no concerns regarding their family members well-being or safety in the home.

The home had policies and procedures in place in regards to safeguarding and whistleblowing. Easy read versions of the policies were available to ensure the information was easily accessible to people who lived in the home. When we spoke to staff about their responsibilities to keep people safe from harm or abuse they referred to the safeguarding policies and confirmed they had received training in safeguarding adults. Where safeguarding concerns had been raised, care workers were able to tell us the different kinds of abuse and whom the referrals were made to.

Any outcomes following safeguarding concerns showed that the agreed preventative measures had been put in place and the guidelines had been followed by staff to minimise further harm to people. Information received by the Care Quality Commission (CQC) demonstrated the registered manager was committed to working in partnership with the local authorities' safeguarding teams.

Staff were familiar with the whistleblowing policy that gave clear guidance and advice of who staff could report to in the event of any concerns they wished to raise in the workplace. The contact information included the provider, the CQC and other external organisations.

Risk assessments were completed within 48 hours of a person arriving in the home. Care plans and risk assessments were stored on electronic records that related to assisting people to mobilise and reducing risks to people who were at high risk of malnutrition, falls, and pressure damage to their skin. Risk assessments had been developed to minimise risks and these were understood and followed by staff. For example, risk assessments identified that some people required walking aids to enable them to mobilise safely and some people required support from two care workers for mobilising and/or transferring safely. Staff quickly interacted and reminded people to use their walking aids when they got up to walk. Records showed staff monitored people's intake of food and drink where they had been assessed at high risk of malnutrition.

People and their relatives told us there was enough staff to support them in the home. One person said, "Well I would definitely call the lady up there, well [the registered manager] is always there." There was a good staff presence and care workers responded quickly to any requests for assistance. Call bells that were placed in people's rooms were in easy reaching distance in the event of any emergencies. The registered manager explained many of the staff had been employees for several years and if they were on leave she would cover additional shifts if required. Due to good staff retention, the provider had not needed to rely on bank or agency staff.

We were told there was one vacant post as the waking night team leader was working their notice, and the

provider was in the process of recruiting for the position. We looked at the rotas and found there was a sufficient number of staff to meet people's needs. Handovers were given before and after each shift. Contracts of employment and the Working Time Directive (WTD) were signed by staff to show they fully understood the responsibilities of their roles. The WTD places a limit on weekly working hours, which staff must not exceed.

The provider followed safe recruitment procedures to ensure background checks were undertaken on staff. Recruitment records were accurately recorded by the administrator who had worked in the home for 11 years. The appropriate background checks had been sought before staff began work. Records included application forms, job descriptions, two references from previous employers, identification checks and interview questionnaires. Criminal records checks were carried out on all the staff and the provider had systems in place to verify if staff were suitable to work with the people who lived in the home.

The arrangements for the management of people's medicines were safe. People told us the staff gave them their medicines at the right time and they were able to speak to the staff if they had any questions regarding their medicines. People commented, "I get to speak to the nurse and if I need any extra, I ask and get what I need" and "I do not have to worry, I get my tablets at the right time."

We observed the senior team leader completing a medicines round during breakfast time. Medicines were stored appropriately within two lockable trollies. Each person using the service had individual blister pack boxes; these were clearly marked with the correct dosage and correlated with the individual Medicines Administration Records (MAR). This included a photograph of the person, date of birth, room number, GP details and any allergies or reactions people may experience.

Each MAR had a colour print out list with each tablet shown individually, to ensure the correct medicines were given to the right person. A register of staff signatures and initials showed that these corresponded to the medicines entries. Where people had refused medicines this was recorded accurately in the MAR.

Written guidelines reflected the individual needs of people and a comprehensive policy included extensive specialist information for staff covering PRN (as needed) and covert medicines. The senior team leader administering the medicine was observed to check with each person and follow accurately each step of the administration process.

Effective systems were in place for ordering medicines with the local pharmacy. Repeat prescriptions for people provided a four-week cycle that showed medicines were being prescribed, ordered and administered in a timely fashion. There was a temperature-controlled room where the fridge was used to store some medicines. We saw that records were held at the correct room temperature and this was checked regularly. Although at the time of the inspection, there were no controlled drugs (CDs) on site, there was a lockable cupboard for the storage of controlled drugs and a CD register. The CD register showed prior entries for controlled drugs and other records demonstrated that any surplus medicines were disposed of safely.

The senior team leader was confident with the systems in place and expressed their ability to carry out a medicines round safely. They reported, "I get to speak to each and every resident and get information regarding their presentation during the interaction." Staff confirmed they had attended medicines training and knew how to report medicines errors if they occurred. A medicines audit showed good responses to any issues raised. We saw that there were contact details for each person's GP when concerns were raised or when there was a recognised change to people's health and well-being.

There were arrangements in place to deal with foreseeable emergencies. There was an appointed first aider and fire marshall, trained to deal with any medical emergencies and fire procedures were in place. Fire practice evacuation drills were regularly held involving both people who lived in the home and the staff. People had specific written plans on how they should be supported when leaving the home in the event of a fire.

To ensure the home was kept safe for people routine servicing was carried out on fire, gas, water and electrical equipment and installations. The provider had a designated health and safety officer on each shift and a maintenance worker was employed to carry out repairs and complete regular health and safety checks on the building.

The home was clean and free from malodours. There was an infection control champion appointed to monitor the prevention and control of infections in the home. Good infection prevention and control are essential to ensure that people who use services receive safe care. The housekeeper showed us the kitchen and laundry areas which were used for people in the home and we found they were used and maintained in line with current legislation and guidance. For example, laundry bags were colour coded to reduce the risk of cross contamination and guidance and notices were displayed on the noticeboard regarding the correct temperatures of the washing cycles. Personal protective equipment (PPE) such as plastic aprons and suitable gloves were available and worn by staff. Control of Substances Hazardous to Health (COSHH) items such as cleaning materials were stored in locked cupboards and records showed where there were identified risks for COSHH items this had been assessed.

Good

Is the service effective?

Our findings

People told us, "The food is always good and I can tell the staff if I do not like it," and "The foods alright, you know." One person told us, "I have had better, more egg and bacon instead of plain bread toasted or buttered or jam sandwich. The cooked breakfast is normally one egg, a couple of rashers of bacon or porridge or cornflakes, I normally take a bit of both." We asked a relative about the food provided for their family member and they told us, "I never had a problem with that and I bring in food too, and if you want tea or whatever it's always been available."

People were provided with a choice of suitable and nutritious food and drink. The home had a protected mealtime policy. This meant that mealtimes focused on avoiding unnecessary interruptions, providing an environment conducive to eating, assisting staff to provide people with support and assistance with meals, whilst placing food as an important aspect of people's well being.

We observed mealtimes using the Short Observation Framework Inspection (SOFI) and found staff interactions with people at mealtimes were positive. A care worker turned the television off. Some people helped the staff to set the tables for lunch with placemats, cutlery, salt and pepper, serviettes and a care worker offered people drinks. A member of staff placed gravy boats on the tables and two plates of food were shown to people to let them know what food options were available. The portion sizes were generous and people were offered second helpings. One care worker assisted a person to eat and talked quietly and reassuringly to the person throughout the meal. One care worker discretely reminded people of any specific dietary needs while giving out desserts. People were offered the choice of what they would like to eat and we observed a person carry their plate from their room back to the dining area. Staff encouraged people to drinks fluids at regular intervals. After lunch people made their way back to the lounge areas or their rooms and people with mobility needs were escorted by the care workers.

People were given supplementary drinks or offered foods such as butter instead of margarine and cream instead of milk to maintain or increase their weight. Records showed that Malnutrition Universal Screening Tools (MUST) were completed on a monthly basis to identify if people were at risk of malnutrition and ensure their weights were within healthy limits. We saw food and fluid charts were documented and people's food preferences and individual dietary requirements were written in their care files.

Weekly menus included a variety of healthy food choices such as fruit and vegetables. People told us there were snacks and drinks available for them throughout the day. One person said, "I like crisps, if you wanted a bag of crisps you just go down to the kitchen and ask." The registered manager told us that foods were available for people who requested this to meet their cultural needs such as Halal and English foods.

There were suitably qualified staff working in the home. Staff told us they received regular supervision, which encouraged them to consider their care practice and identify areas for development. The administrator had completed a diploma in business administration, and the housekeeper had a diploma in hotel and housekeeping. The maintenance worker previously worked as a care worker in the home and the provider had supported the member of staff to attend college to work towards a recognised national

vocational qualification in maintenance. This meant the provider recognised the value of employing staff with an understanding of people's needs in non-caring roles. All the staff that worked in the home had completed a recognised national vocational qualification in Health and Social Care.

We saw that staff were well supported by the registered manager and any training or performance issues were identified. Yearly appraisals of work performance were held with care staff and the registered manager to review their personal development and competence.

Staff had completed the organisation's induction training and the staff described the induction as "very good". Staff training records showed they had completed training in moving and handling, medicines, fire safety and dementia awareness that comprised face to face learning and e-learning. The staff also attended team meetings that were held every two months to give staff the opportunity to discuss best practice regarding how to support people and any areas of concern.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When 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.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We saw records to show that where people had been deprived of their liberty applications had been made to the local authority and best interests meetings had taken place in line with the MCA framework. Staff had completed MCA and DoLS training and during discussions with care workers, we found that they fully understood the principles of the MCA. We saw that staff obtained people's consent before carrying out any aspect of care and relatives had been involved in any decision making on behalf of their family member where appropriate. One relative said, "They have always took on-board my view and what I think is best for my [family member]." The registered manager understood the principles of the MCA and DoLS and we saw that best interests meetings had been held with people in the home. Consent forms had been signed by people to show they had agreed to the care and support they received.

People told us they had access to health care and had no difficulty accessing support with their health care needs. One person told us, "I go when I need a doctor, he comes to me. When he comes by here he checks on me" and another said, "If they think I need [a GP] they might get me one, they'll buzz them." When we spoke to a relative, they confirmed what people had told us and explained, "Yes staff are on the ball if I think something is not right, they're on the phone to the GP if they can't deal with it."

Care plans contained a record of input from health and social care professionals. There was a separate set of written records pertaining to district nurse visits and where people had pressure ulcers we found they had been assessed by the tissue viability nurse and staff followed the correct procedures. The registered manager had been trained in the care of pressure areas and used her knowledge to support staff to provide appropriate care. People had specialist equipment such as cushions, mattresses and hoists and information and advice was given to people in welcome packs regarding pressure ulcer prevention when they moved into the home.

We spoke to the district nurses who visited the home daily to support people with their health needs. They

were complimentary about the staff responses to the health advice they gave and acknowledged there was a high quality continence management system in place to support people with their personal care. We saw that where people had difficulty with eating, drinking or swallowing referrals were made to the speech and language therapist (SALT) for an assessment of their needs. Podiatrists were available to visit people in the home when they requested.

Staff recognised the signs and triggers when people's needs could change and explained how this was reported and acted upon. Two care workers explained, "We always observe the residents and if there is a change report it to the senior in charge" and another said, "Any signs or changes in walking or eating could be telling me that they are becoming ill." Care files showed that people had attended regular appointments with GPs, physiotherapist, dentists and opticians, and contained a recorded input from health professionals. There was a monthly GP meeting in the home to monitor people's health and well-being.

Good

Is the service caring?

Our findings

During the inspection we observed that people were treated with kindness and compassion. People told us, "The staff always have time to talk and listen," and "They're very friendly." Another person said, "They're always helpful."

People's individual preferences and differences were recognised and respected. The registered manager explained people were chosen to be included in 'my special day' once a month, which helped staff to understand the needs and wishes of people who lived in the home. The day involved a person being visited by the administrator, cook, housekeeper and registered manager to discuss the person's needs and wishes and their room was deep cleaned. Photographs of people were nicely displayed in the communal hallways of the trips they had attended or hobbies they took part in for the 'special day' such as a meal out or a visit to the park. This demonstrated that people's wishes and preferences were recognised, valued and celebrated.

We observed staff interactions with people and saw they were approachable, professional and sincere. Staff acted in a professional and friendly manner and told us the culture of the workplace was that of a family environment. A relative reported the staff were "polite and caring."

People were encouraged to maintain positive relationships with family, friends and staff. A relative explained, "When [staff] are on duty they tell me if my [family member] has had a good day or a good night. They come over and talk to him/her." We saw relatives and friends visiting people in the home and taking them out for the day. People were offered advocacy support when needed which meant their views and wishes were genuinely considered when decisions were being made about their lives.

The provider had a 'privacy, dignity, rights and choice' policy that all the staff followed, and the commitment to this was outlined in people's information packs given to people when they first moved into the home. We saw in people's records where they had requested care workers of the same gender to support them with personal care, which was met by the home. People told us they were treated respectfully and that staff knocked on their door before entering. One person said, "To wake me up they knock on the door," and another commented, "Yes I'm treated in private."

There was a quiet room where people could peacefully relax and speak to their relatives, friends and staff privately. One person said, "There is a public area but there is a private area away from everyone or the smoking room area."

Information about people's life history was also included and showed that some people's relatives had been involved in care planning. All the staff knew people well and had a good understanding of their personal histories and preferences. One care worker said "I like getting involved with the history of residents, it helps me with looking after them and gives me a chance to talk to them about their past."

The senior team leader said, "We record the likes and dislikes of each individual resident and get to know

them well." We saw the care workers offered people the choice of where to eat meals and where to sit. During the course of the day, there was a sense of good-natured exchanges and communication between people and staff. People were spoken to in a kind manner and staff were seen to be attentive and caring when supporting people. For example, we saw staff talked to people in a quiet, gentle way and always responded to any questions they had. We also noticed that where people needed intensive one to one or two to one support, this was observed to be relaxed and unobtrusive.

The communal areas were well decorated and homely and people's rooms were personalised with belongings and items that were important to them. Several people had their own furniture and some people had received new hospital style beds to support them with their health care needs. A person proudly showed us their room and another said, "The staff have time for you, they never rush" and another explained to us, "I never worry when I need anything, my room has everything I need." People's names were placed on their room doors to help people with their orientation so they could identify and locate their own rooms with ease.

Advanced care wishes were written in people's care plans on how people wished to be supported with their end of life needs and evidence of discussions was recorded. These were reviewed regularly to ensure people's needs were met. The home was working towards the Gold Standard Framework (GSF) so that they may become GSF accredited. The GSF offers training to all staff providing end of life care to ensure better experiences for people.

Good

Is the service responsive?

Our findings

The people we spoke to were clear with regard to their views of the home and the provision of care and support. One person said, "Staff are very good and aware of what I need," and another person told us, "I enjoy being in my room, it is very tidy like a hotel, I know where the staff are if I need them." One person explained how staff did not encroach on their private time, "Staff are there when you need them but not in the way all the time."

Some people who lived in the home had no relatives and we saw where people were included in specific activities to reduce social isolation and loneliness. The home worked with 'Magic Me' volunteers who support older people to participate in inter-generational social activities in order to combat the potential isolation associated with the ageing process. This meant that people could participate in the activities of their choosing and created opportunities for people to become friends with local volunteers. One such activity was 'Cocktails in care homes'. This was a regularly held social event that people looked forward to and dressed up for, so they could socialise with each other, staff and volunteers. In one care file, we found a person had chosen to move from the second to the third floor where there was a communal area so that they could interact with other people in the home.

People talked to us about the activities they attended and what they would like to do. One person said, "We play a game of cards or dominoes, yeah I have a go at dominoes," and "I like playing card and draughts; I like to look at the games book to find out more. Normally you can watch TV shows in the afternoon." Another person commented, "I like any sports or nice food looking pretty on the plate. Cricket, football I like to see tennis but I can't play it properly. They have a game from home called marbles I'd like to play that". One person explained that they liked to read the newspapers and another commented they would like to play monopoly as they grew up with playing the game.

Throughout the day, we saw activities taking place that had good numbers of people attending. We saw people taking part in a pedicure, listening to music and enjoying a movie. The home had its own brightly coloured 'reminisce popcorn stall' that was located in the communal area which held jars of popcorn and treats that people could help themselves to before the movie commenced. We saw one person playing their own card game. Activity timetables included manicures, listening to music, dominoes and seated exercises. There was a large garden area with comfortable seating areas and we observed that people were relaxed and content in their surroundings.

People in the home had joined the 'Monday Club' and visited the local farm. The farm had a space to grow their own fruit, vegetables and flowers that people could purchase. People were involved in 'grow your own sandwich' and could grow their own tomatoes and radishes they had picked and used for sandwiches. A project called 'Furry Tales' was held fortnightly that connected older people with animals. A volunteer worker visited the home and brought a variety of animals for people to stroke and learn about. One person told us they enjoyed attending the club and pictures of people who attended were published in the provider's newsletter and distributed to people in the home. There was a reminiscence corner, where mannequins were on display, styled in period dress and accessorised with scarves and beads. The registered

manager explained the therapeutic benefits of the activities and reminiscence displays for people living with dementia.

A hairdresser visited the home regularly and aromatherapy and reflexology were available for people if they wished. The registered manager explained the importance of people maintaining their independence, "We encourage people to do things for themselves or you will de-skill them, it's important the residents' maintain their independence." People were encouraged to go shopping with relatives, friends or independently. Where people required more support, shopping trips were arranged and people were helped by staff to purchase goods on their behalf.

Residents' meetings were held for people to give their views, opinions and suggestions. One person told us the meetings were an opportunity to learn from other people who lived in the home. The person explained, "I like going to some of the meetings, I feel better because things that bother me I can get it off of my chest. I can speak to some of the residents and they can advise me on what to do, they are very helpful. In some meetings I listen to other people talking, I learn from them."

Staff supported people to meet their religious and cultural needs by celebrating festivals and attending places of worship of their chosen faith. We saw in people's care plans where their cultural identity was important to them, this was recorded. Records showed 'how' a person liked to eat and advanced planning included people's cultural preferences. Another person's file showed how they enjoyed reading a book of their religious beliefs and singing spiritual/holy songs. This showed us that people's cultural identity was recognised and valued.

The care and support people required was given in a personalised manner and reflected the needs of the individual people. During the inspection, we saw examples of the care workers responses to a variety of issues and these were dealt with in a calm and highly skilled manner. The registered manager said, "It's about adapting yourself to the individual, the relationships the staff have with the residents' makes their day."

People told us if they had a concern, they would speak to member of staff or the registered manager and felt confident their concerns would be dealt with satisfactorily. People's information packs about the home gave clear guidelines on the complaints procedures. Any complaints raised by people had been actioned and responded to in a timely manner.

Care plans were stored electronically and a paper copy was kept on file. There was evidence timely reviews of care plans met the changing needs of people, this included changes of medicines and change of moving and handling requirements. The electronic care plans listed what people could and could not do and how they could improve.

The daily routines that we observed were well organised with staff being aware of the routines required, however there was little written evidence in the electronic records to show the person centred approach that we observed people received in the home. For example, we looked at the care records of some people who were living with dementia and some people who required less support. We found some people's personal histories were recorded although these were generally written as a very brief description on the electronic files and needed to give more person centred explanations of people's background and histories. This included information about people's occupation(s), which was written in brief sentence. We found for one person the activities they had attended had not been recorded. For example, we observed where a person had a pedicure and showed the Inspector their room. We viewed the daily records on the following day for the person and found no written record of the activity.

We recommend that the service seeks advice and guidance from a reputable source, based on current and best practice, in relation to recording person centred care in people's files.

Good

Is the service well-led?

Our findings

People using the service, their relatives and staff gave very positive views about the registered manager. One person told us the care home was 'well organised'. Staff described the registered manager as "approachable", and "a very good boss" and described the home as "well-run". One relative told us they "put the resident's first."

The registered manager maintained a visible and regular presence and had worked in the home for a number of years. There was a culture and general consensus between staff that the registered manager was fair, open and always responsive to staff suggestions and requirements. The registered manager had completed training that was reflective of the needs of the people who lived in the home. This included a higher national vocational qualification in health and social care, person centred care, and a leadership and support programme.

The provider's philosophy of care stated 'Our aim is to look after each person in a home from home environment creating a homely atmosphere and quality services which meet the individual needs of each person'. The registered manager promoted a work culture that was family orientated and that put people first. The staff team were committed to this idea and spoke positively about promoting choice and independence for all people within the home.

Surveys were sent to people and their relatives to give their ideas and suggestions on how the provider could improve the service and the results were mainly positive. The registered manager reported she had organised relatives' meetings, however due to the low attendance had held one to one meetings called 'relatives' discussions' that were recorded on file. The register manager told us, "My door is always open." The home had received compliments about the care the staff provided and one person said, "They're all quite nice."

The registered manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they occurred. The provider kept up to date with relevant areas of good practice through membership of a number of professional organisations. Benchmarking was used by the provider to set new standards of practice such as the National Minimum Data Set for Social Care (NMDS-SC). NMDS-SC is an online system which collects information on the adult social care workforce in England.

Good systems were in place to monitor and improve the quality of care people received. The registered manager operated a range of audits and scheduled checks within the home. Where audits or observations identified concerns, clear actions were implemented. For example, the registered manager took part in unannounced spot checks at night time and during weekends. Additionally, the local authority carried out monitoring visits and any shortfalls found were acted on and clear improvements made.

People were protected from risk as the registered manager ensured lessons were learnt from any incident and accidents to protect them from further harm. They used this information to identify any trends around

accidents and incidents. The systems of record keeping and documentation seen was very well organised and all information asked for was on hand and readily available.