Greystones Nursing Home Ltd

Greystones Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

Our inspection of Greystones Nursing Home took place on 20 December 2017 and was unannounced.

Greystones Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Greystones Nursing Home provides nursing and personal care for up to 25 people, some of whom are living with dementia or have mental health needs. There were 22 people using the service when we inspected. Accommodation is provided in single and shared bedrooms over three floors. There is a passenger lift to the first floor and chair lift access to the second floor. There is a lounge, dining room and smoking room on the ground floor.

The home has 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.

Policies and procedures ensured people were protected from the risk of abuse and avoidable harm. Staff told us they had regular safeguarding training, and were confident they knew how to recognise and report potential abuse. Where concerns had been brought to the registered manager's attention, they had worked in partnership with the relevant authorities to make sure issues were fully investigated and appropriate action taken to support people's safety and protection.

Comprehensive risk assessments identified individual risks to people's health and safety and there was information in each person's care plan showing how they should be supported to manage these risks. Systems were in place to ensure people received their prescribed medicines safely.

There were enough staff on duty to meet people's needs and staff had undertaken training relevant to their roles. Staff told us there were clear lines of communication and accountability within the home and they were kept informed of any changes in policies and procedures or anything that might affect people's care and treatment.

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

People told us they enjoyed the food. We saw staff members were proactive in supporting people to maintain their fluid and food intake; especially people identified as being at risk of malnutrition. However, we found food charts had not been completed accurately to carry out recommendations of the Speech and Language Therapist (SALT). We have made a recommendation about food charts not accurately reflecting

the risk of malnutrition.

We saw the complaints policy had been made available to everyone who used the service. The policy detailed the arrangements for raising complaints, responding to complaints and the expected timescales within which a response would be received.

The care plans in place were person centred and identified specific risks to people's health and general well-being; such as falls, mobility, nutrition and skin integrity.

We saw arrangements were in place that ensured people's health needs were met. For example, people had access to the full range of NHS services. This included GPs, hospital consultants, community health nurses, opticians, chiropodists and dentists.

Relatives told us they were made welcome and encouraged to visit the home as often as they wished. They said the service was good at keeping them informed and involving them in decisions about their relative's care.

There was a quality assurance monitoring system in place that was designed to continually monitor and identify shortfalls in service provision.

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 consistently safe.

Foods recorded as being safe were not in keeping with people's dietary risk assessment plans.

People were protected by staff who knew how to recognise and report any concerns about their safety and welfare.

There were enough staff available to meet people's care needs safely. Appropriate checks were completed before new staff started work which ensured they were suitable to work in a care setting.

The home was clean, odour free and risks to people's safety were identified and managed. People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were supported by staff that received appropriate training and supervision.

People's rights were protected because the service was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were referred to relevant healthcare professionals if appropriate and staff followed their advice and guidance.

People's nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were cared for by kind and caring staff that went out of their way to help them and promote their well-being.

People were supported to maintain on-going relationships with

their families and could see them in private whenever they wished.

The service provided effective care and support to people and their families at the end of their life.

Is the service responsive?

Good

The service was responsive.

People's care plans reflected their individual needs and were reviewed and updated as their needs changed.

There was a range of activities for people to participate in, including activities and events in the home and in the community.

There was a complaints procedure in place and people felt confident that if they made a complaint it would be dealt with appropriately and in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a registered manager in post who provided leadership and direction to the staff team.

Wherever possible both people who lived at the home and staff were involved in all aspects of service delivery.

The provider had implemented new quality assurance systems to check the quality and safety of the service. However, care plans seen did not reflect the identified actions following risk assessments which had been undertaken.

Greystones Nursing 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 checked 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.

We carried out this unannounced inspection on Wednesday 20 December 2017. This meant the provider did not know we would be visiting the home on this day. The inspection team consisted of two inspectors from the CQC (Care Quality Commission), one of whom is a Registered Mental Health Nurse (RMN) and an expert-by-experience with a background in supporting people to use this type of service.

Before the inspection we reviewed all the information we held about the service, including past inspection reports and notifications sent by the provider about key incidents and events, which they are required to tell us about by law. We contacted people who commission services from the provider, safeguarding teams and other bodies such as Healthwatch to ask if they had any significant information to share. Healthwatch is an independent consumer champion that represents the views of people who use health and social care services in England. We did not receive any information of concern.

Before the inspection we asked the provider to complete 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. The provider completed the PIR and returned it to us in a timely manner and this was taken into account when we made judgements in this report.

During the inspection, we used a variety of methods to find out about the experiences of people who used the service. We spoke with the registered manager, five care staff and two visiting health professionals. We also spoke with 13 people who used the service and one relative. As it was evident people were able to speak with us and share their experiences, we observed care and support but did not carry out a Short Observational Framework (SOFI) on this occasion. We looked at records relating to care and support including five people's care plans, medicines records for five people and a sample of information about the running of the home including audits, maintenance records and four staff files.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Greystones Nursing Home. People said, "I like it here and I feel safe with the staff." "I like living here and I do feel very safe." "I am well looked after." "I'm looked after and I have no worries, staff treat me well, this is my home." "I'm in as good a place as I can be."

The visitor said, "My 'relative' is well looked after and I feel confident leaving 'them' here." They also said, "Staff come in to see 'them' every hour and keep me informed about 'their' care and medication". We saw the person had difficulty speaking due to their physical health condition but was nodding and smiling in agreement with what their visiting relative was saying. They also indicated they were pleased living at the home and commented; "Oh yes, happy." The person also stated that they liked their room.

One healthcare professional spoken with said, "I'm very confident the person I see is very safe here." The other healthcare professional said, "Everybody is safe here. I've no concerns whatsoever; people are content, the home is clean, and it's absolutely lovely."

At this inspection, we found risk assessments and care plans were reflective of people's current needs and contained the required information to manage the identified risk. However, we found food charts had not been completed accurately to carry out recommendations of the Speech and Language Therapist (SALT).

We looked at three people's care records that were identified as requiring a soft diet by SALT. We saw risk assessments and care plans had been updated in a timely way following SALT assessments, which meant staff had the required information to mitigate risks associated with people's dietary needs. There was a nutrition risk file which detailed people's needs and the cook had the same information to ensure food was prepared in line with people's requirements. However, we cross referenced this information with the food and fluid records of the three persons on special diets and saw the way staff recorded the food given was not appropriate.

We noted some of the foods listed would be considered high risk foods and should not be given to people assessed as having an 'unsafe' swallow due to the risk of choking or aspiration. Aspiration is when food goes down the windpipe and into the lung. High risk foods may include sausage rolls and biscuits.

We asked staff and the registered manager about the foods listed that would not be considered in keeping with the needs of the three persons requiring a soft diet. We then established that pastry had been removed from the sausage roll and the sausage meat was pureed and biscuits had been soaked in tea. All the staff spoken with demonstrated a good understanding of these people's needs and we concluded the error was in the recording of foods on the nutrition risk file and not that people had been exposed to the risk of harm.

This was discussed with the registered manager and we recommend that the service review the recording of foods to ensure it shows people are not at risk of harm.

We saw there were safe recruitment practices in operation at the home. Staff files we looked at contained

evidence of background checks being made; including requesting references and making checks with the Disclosure and Barring Service (DBS). The DBS is a national agency which holds information about people who may be barred from working with vulnerable people.

We asked people if they thought there was enough staff and the feedback was good. One person told us they thought staff was always on hand and did a good job. They said, "Always helpful and there when I need them." "Yes, plenty of staff."

The registered manager told us sufficient staff were employed and staffing levels were based on people's needs. The staff we spoke with confirmed there were enough staff on duty to ensure people received safe and appropriate care. During the inspection we saw staff responded to people courteously and people were not waiting for long periods. One staff member said, "I feel there is enough staff. We are busy but we keep ourselves busy too. We've come here to work." We looked at the staff rotas for two months and concluded staff levels were sufficient to provide safe care and support to people who used the service.

Staff we spoke with understood how to recognise signs of potential abuse, and how to report any concerns. They told us they had confidence the manager would act on any concerns raised with them, and knew they could also make reports to other bodies such as the local authority and CQC. We saw training in this area was kept up to date, which meant the provider was ensuring staff had annual reminders of the importance of protecting people and the systems in place to ensure policies were followed at all times.

Staff told us the provider had a whistleblowing procedure which they had seen. We also saw evidence of this. 'Whistleblowing' is when a worker reports suspected wrongdoing at work.

We saw written evidence the provider had notified the local authority and the CQC of safeguarding incidents. The service had taken immediate action when incidents occurred in order to protect people and minimize the risk of further incidents.

Accidents and incidents were reported in a timely way, and we saw the provider had a lessons learnt culture which involved discussions of any incidents in staff meetings.

We saw the registered manager had an effective system in place for monitoring and managing accidents and incidents. The registered manager analysed accidents/incidents each month. The monthly accident log detailed the common themes/trends, where the incident occurred, whether an injury was sustained and contributing factors; for example, if there had been new admissions to the home that had changed the dynamics of the service. This meant the registered manager had systems in place to monitor trends regarding accident/incidents and also put strategies in place to mitigate the risks of future re-occurrence.

A falls risk assessment tool (FRAT) had been completed for those people identified as experiencing falls. The home had a falls champion who gave support and guidance to staff.
If people were risk assessed as being unable to use the call bell; they were checked every 60 minutes. We saw evidence of this on charts.

We saw personal emergency evacuation plans (PEEPS) were in place for people who used the service. PEEPS provide staff with information about how they could ensure an individual's safe evacuation from the premises in the event of an emergency. We saw evidence of PEEPS based on people's physical abilities, ability to understand verbal instructions and willingness to follow instruction.

We looked at how the service managed people's pressure care. At the time of the inspection no people living

at the home had any pressure sores. We saw pressure risk assessment tools were consistently completed to help reduce the risk of pressure sores. When people had been identified as being at risk, we saw people had the required equipment to provide a reduction in pressure on vulnerable areas to prevent skin breakdown occurring.

At the last inspection we found issues around medicines administration practices. At this inspection we found the registered manager had addressed this. We looked at how medicines were managed and observed senior staff during the lunch time medicines round. The staff member was calm and efficient and followed good practices to ensure medicines were administered safely. Some medicines were prescribed with special instructions about how they should be taken in relation to food. We saw there were arrangements in place to make sure these instructions were followed.

We looked at seven random medication administration records (MARs). The MAR sheets were checked and administration was found to be accurate in terms of stock held. All MARs had a photograph of the individual person for identification purposes. Any incidents of non-administration or refusals of medicines were noted and signed on the MAR sheets.

We saw medicines prescribed on an 'as and when required' basis (PRN) drugs were in place at the home. It was noted that there were protocol sheets with the MAR records indicating the rationale as to when they could be given and why. This meant there was guidance in place for staff to follow.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called control drugs (CDs). We saw records of CDs were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Where medication errors had occurred previously, we saw these had been investigated and action taken to prevent a re-occurrence. A low number of medicines errors had occurred within the service.

We looked at medication storage and saw the medicines required for all persons were well stored and secure. Daily temperature records confirmed that medicines were stored within the recommended temperature ranges to guarantee their safety and effectiveness. The storage of CDs which are medicines which require extra security was managed safely.

Arrangements were in place to ensure timely deliveries were made. This meant people were not put at risk by medicines not being available when they needed them. Stock control systems were in place, such as regular audits and running counts of medicines as they were administered, which meant errors could be identified in a timely way. We saw staff had received appropriate medicine training and had on going competency checks to ensure medicines were being administered safely.

People told us they received their medicines when they needed them, and appropriate consent had been obtained for staff to administer these to people.

Some people were prescribed topical medicines such as creams. We saw body maps were in place which provided guidance to staff on how to apply these medicines. Topical medicine administration records were well completed indicating people regularly received their prescribed creams. We saw creams contained the date of opening to ensure these did not pass their safe 'use by' date.

Medicines for return to the pharmacy were sent through as required. This medication was recorded in a specific book for this purpose. Any unused medication and clinical waste was collected and signed for by

external specialists as required.

We saw gloves and aprons and hand gel in several locations throughout the home. We also saw staff wore protective aprons and gloves when carrying out care and support duties. This meant the service had taken appropriate actions to prevent and control the spread of infection.

The registered manager told us money was held in safekeeping for several people and transactions were dealt with by care staff. We checked the money and records of five people and found monies were managed safely.

We looked around the premises including people's private bedroom accommodation and communal areas. We found all areas of the home to be clean and well maintained, suitably furnished and free from offensive odours. We saw there was a new unit built onto the home, providing five new bedrooms, a dayroom, a treatment room for beauty treatments such as pedicures, a small cinema, and a smoking room which was due to be opened.

We inspected maintenance and service records for the gas safety, electrical installations, water quality, fire detection systems and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested as required and equipment such as hoists was regularly serviced and kept in good condition.

Good

Is the service effective?

Our findings

We looked at records relating to staff support. We saw staff completed a comprehensive induction. As a part of their induction we saw new staff spent time shadowing more experienced members of staff, to help them understand how care and support was delivered. New staff did not begin working without this oversight until they and senior staff were confident in their ability to provide care effectively.

We looked at staff records and the training matrix. We saw training was either completed, booked, or in the process of being signed off as completed. Staff were required to complete a number of courses including fire safety, moving and handling, infection control, safeguarding, health and safety, nutrition, dignity and respect.

We saw the registered manager had a planned programme of supervision and appraisal meetings with individual staff members and their training and personal development needs were identified during these meetings. The staff we spoke with told us they felt well supported by the registered manager and senior staff team and the training provided equipped them to meet the needs of people living at the home.

The registered manager told us the service had a good working relationship with other healthcare professionals to ensure people received appropriate care and treatment. Care records we reviewed and our discussions with staff showed people were supported to access healthcare services such as GPs, dentists, opticians, chiropodists, dieticians and the community nurse.

A healthcare professional we spoke with said, "They are really on top of [person's] food, fluids and medical needs." We saw a health care checklist that identified the information required regarding people's health and social care needs which was to be passed to the hospital should an admission occur.

We found some people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place. These had been completed by relevant clinicians. There was evidence of family involvement in the decision. Staff we spoke with had accurate knowledge of which people had DNACPR arrangements in place.

People had good access to healthcare as an approved nurse practitioner (ANP) visited the home weekly and undertook general reviews of everyone's health. If a person living at the home required a more in depth consultation, staff from the home rang the ANP in advance of their attendance at the home so they could bring the person's medical notes to support assessment and decision making. The ANP is able to organise admission, chiropody, or a GP appointment if required.

We saw the home had also installed the Tele-Care system. This is an interactive healthcare system that utilizes visual collaboration technology. If a person required a medical consultation, staff could take the lap top to the person in their bedroom and the consultation occurred via the lap top using the video calling system 'Skype'. The Tele-Care system was able to accommodate different medical consultations including; general clinics and psychiatric reviews. The system is also able to liaise directly with the local hospital to arrange admission and/or prescription and delivery of medicines to the home if required. The benefit of this

system is that people were not required to leave the home in order to seek medical attention. Staff had access to the Tele-Care system 24 hours a day, seven days per week which meant people had responsive access to medical professionals as and when needed.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 and found conditions on authorisations to deprive a person of their liberty were being met. The manager maintained a DoLS matrix which identified the following; the person's name, date on which the application was submitted, whether the application was standard or urgent, the name of the local authority involved in the decision, the decision made, the date of expiry and the date to re-apply. We saw recommendations identified on the DoLS paperwork were documented in the care plans.

We asked staff about MCA and DoLS to ascertain their understanding. All staff confirmed they had received training and demonstrated they had a good understanding of both MCA and DoLS. One staff member said; "We always assume people have capacity. If the person is deemed not to have capacity to consent to living here, then they would require a DoLS. If people haven't got capacity, then they have an advocate involved to speak on their behalf and support decisions." A second staff member said; "People are different. A person may have capacity to manage their finances but not recognise their care needs. It's decision specific."

Needs assessments were completed by the management team before people moved into the home. This encompassed people's needs and choices and the support they required from staff, as well as any assistive technology in helping them to perform activities of daily living to keep them safe and promote independence. This process helped to ensure people's needs could be met by the service.

We saw people had consented to their care. When people were deemed not to have capacity to consent, best interest meetings had been held and their next of kin had signed to consent on their behalf.

We saw the Malnutrition Universal Screening Tool (MUST) was in place. This is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. We saw these had been completed and updated in a timely manner to reflect people's changing needs. We saw people's weights were closely monitored. People's weights were recorded weekly and the records we viewed showed staff had been responsive to people's varying needs and requirements. We saw people had been referred to the community dieticians and commenced on fortified foods, and high calorie snacks as per dietician recommendations when required.

Menus were displayed in the dining room and showed a wide variety of meals were available as well as a choice of drinks and snacks. We saw people helping themselves to fresh fruit which was available in the communal areas throughout the day. We asked one person if this was usually provided and they said, "Yes", and told us there was fresh fruit around communal areas every day. Other snacks and drinks were provided throughout the day.

At mealtimes we saw people's individual preferences were catered for which included where they wanted to have their meals as well as what they wanted to eat and drink. Some people chose to eat in the dining room, while others preferred to eat in the lounge or their own rooms. There was a relaxed atmosphere as staff were well organised and provided assistance to people in a calm and patient manner.

We spoke with the cook and our discussions confirmed their knowledge of people's dietary requirements. They kept information about people's dietary needs in a file in the kitchen. The cook explained all meals were freshly cooked and fortified meals were prepared for those who required this. The cook told us the manager and senior staff informed them of any changes needed to people's food/diet requirements. People's weight was monitored and any changes discussed with the GP or district nursing team. The cook demonstrated a good knowledge of people's likes and dislikes and was flexible in the preparation of whatever people wanted.

Staff regularly consulted with people on what type of food they prefer and ensure foods are available to meet peoples' diverse needs. We saw people had a choice of two main meals at each mealtime. We saw staff asking each person which they preferred. People told us the registered manager and cook regularly discuss with them menu choice.

We found some improvements had been made to the environment to help people living with dementia find their way around the home. For example, bathroom and toilet doors as well as having pictorial signs had been painted a different colour from other doors to help people recognise them more easily. Toilet seats were blue which made them clearer for people to distinguish. Pictorial signs were on bedroom doors and there were meaningful photographs or pictures to help people identify their own rooms. The registered manager told us of on going plans to introduce more colour and signage to further enhance the environment for people living with dementia.

Good

Is the service caring?

Our findings

People told us staff were caring or very caring. One person said, "The staff are caring and will do anything for you." Another said, "It is my home and (staff) feel like family. One staff member in particular is 'like a daughter to me." Other comments included "Best home I've ever been in." "The owner is kind and good." and "The manager is kind and caring…full marks."

Our observations supported this and we saw staff showed kindness and compassion to people. For example; a person was seen to be distressed, we noted staff became aware of this and when this person didn't settle, staff intervened and assisted them. The outcome of this was the person calmed down. People showed signs of being happy with their care. We saw people smiling, laughing and joking with staff and each other. We found staff friendly and welcoming. There was a calm, relaxed atmosphere in the home.

We found people's needs were assessed and their care and treatment was planned and delivered in line with their individual care plan. We saw the care plans for people who used the service contained 'Life story' information and details of their interests and hobbies. People looked relaxed and comfortable around staff. There was a calm, friendly atmosphere and we saw staff took time to sit and chat with people. We observed care and support and saw staff treated people with kindness, dignity and respect. Interactions were consistently positive and it was clear staff had developed good, positive relationships with people and knew them well.

Staff told us they encouraged people to be as independent as they could. For example, they described how they helped people to choose what they were going to wear, by opening their wardrobe and giving them various options. They told us some people would help to make their own drinks. They talked with fondness about the people living in the home, and their commitment to providing the best care possible.

One staff member spoken with said. "I'm always in a jolly mood, upbeat and motivated. Everything's people's choice. I'm always talking to people and finding out what they want. Sometimes people won't wear the right clothes for the weather but we'll point out the weather (conditions), that it's very cold (for example) and encourage them to wear a coat too." Another staff member said, "We always offer choice. Sometimes we may have to identify choices for people to choose from but everything is down to what the person wants."

Staff also told us, "Most people can do things for themselves but may not recognise their needs so we just prompt verbally. Other people need more support so it's tailored to the person."

We observed people being addressed by the staff using their preferred names and the staff knocked on people's doors before entering their room. When personal care was being given, the staff made sure that the doors to people's rooms remained closed to ensure privacy and dignity was maintained. We saw people's bedrooms had been personalised with photographs and ornaments. People's clothing had been put away tidily in wardrobes and drawers showing staff respected people's belongings.

We saw people were supported to maintain on going relationships with their families and could see them in private whenever they wished. One relative we spoke with said they visited the home on a regular basis and were always made to feel welcome and offered light refreshments.

We looked at how the service worked within the principles of the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Staff gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to disability, gender, ethnicity, faith and sexual orientation. These needs were recorded in care plans and all staff we spoke with knew the needs of each person well. People also commented on how well their individual needs were met. We saw no evidence that anyone living in the home was discriminated against.

We saw the service had policies and procedures in relation to protecting people's confidential information which showed they placed importance on ensuring people's rights, privacy and dignity were respected. We saw staff had received information about handling confidential information and on keeping people's personal information safe. All care records were stored securely to maintain people's confidentiality.

Good

Is the service responsive?

Our findings

In the care plans we reviewed we saw initial assessments had been completed which included; a summary of medical information and care needs, social information; interests and hobbies, daily routines, likes and dislikes, skills and abilities, strengths, relationships, culture and religion. This meant staff had the necessary information prior to people moving into the home to formulate plans based on people's needs.

People received care that was responsive to their needs and personalised to their wishes and preferences. Each person had a care plan that was tailored to meet their individual needs. We saw people had 'My life history' documentation completed. Information captured included; people's culture and religious needs, life histories, background information, employment history, interests, likes and dislikes. In one person's care file, the care plan contained comprehensive life history information about the person's childhood, work life, significant relationships, life events and achievements and interests. Staff were very knowledgeable when asked about people's individual needs and were motivated to ensure people received care that was person centred and ensured people's personal preferences and wishes were met.

All the people we spoke with expressed their general satisfaction with the care provided. One relative said, "This is the best place for (them). I wouldn't have (them) anywhere else, (they) get exceptional care."

We saw people had varying complex needs that were care planned .Care plans included; mental health, challenging behaviour, violence and aggression, nursing assessment, specialist medical needs care plans, dietary information, mobility, sleep, pain, likes and dislikes.

Staff were identified as keyworkers for people which meant they were responsible for a number of people living at the service and ensuring their needs were being met.

People's care was also reviewed in conjunction with their care coordinator through the care programme approach (CPA). A CPA is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or with a range of related complex needs. A care coordinator is identified and oversees the CPA and they are responsible for planning the care and support people receive.

The registered manager explained the importance of ensuring family members were well supported when their relative was approaching the end of their lives. They told us families were the ones who were left behind when a person died and therefore it was extremely important they supported them through this difficult period. We saw end of lives information recorded in peoples care plans.

The registered manager told us the service previously had a set weekly activities programme but people had not engaged well with this. Currently the set activities consisted of bingo and armchair aerobics which occurred on Tuesday and was paid for by people who used the service. The provider also arranged and paid for 'music fun' every three months which involved an independent company that played musical instruments with people. Other available activities included karaoke and baking sessions. The home previously had a bowling team and it was the registered manager's intention in the new year to try to re-

establish a bowling team and enter the local league. People had an interest in art and painting and the registered manager had approached a local college to see if art students would be interested in coming to the home and supporting art projects. Trips were arranged as people requested and these included taking people on a one to one basis to the seaside, museums, a local castle and shopping.

We saw the service had a complaints procedure which was available to people who used the service as well as their relatives. The staff we spoke with told us they were aware of the complaints procedures and were able to describe how they would deal with and address any issues people raised with them. We looked at the complaints register and saw two formal complaints had been received since the last inspection. We saw these complaints had been dealt with appropriately by the registered manager and the complainants were happy with the response received.

People who used the service and the relatives we spoke with told us they did not have any concerns or complaints but knew who to speak with if they had any concerns. One person said, "If I have a problem I speak with the staff and they sort it out." Another person said, "I have never complained but if I did I am sure (Name of manager) would sort it out for me." The registered manager told us they were pro-active in making sure low level complaints and concerns were dealt with before they escalated to a formal complaint. They also told us complaints were welcomed as they were used as 'a learning tool' to improve the service for everyone.

We saw the service had received several compliments. Examples included; 'You manage a lovely home.' 'The staff are dedicated and professional. The décor is now bright and cheerful. It's a much more inviting home than it used to be. The staff and management are always welcoming and the whole team is a credit to your leadership.' 'Amazing care of [person]. I know there are challenges but I love your relationship and approach with them.' 'It's always a positive experience working with the team. 'There is always good communication.' 'Organised and caring establishment. Care is planned and responsive to people's changing needs'. 'The staff are constant which is a positive. The staff are respectful, polite, always available. I would happily recommend this home.' 'Fabulous care you gave [name of relative]. You all have got it right, it should be a template for care across the world.' 'Thank you all, as always for the wonderful care you give [name of person] every day. I love you all.'

We looked at what the service was doing to meet the Accessible Information Standard. We saw people's communication needs were assessed and plans of care put in place to help staff meet these. During the inspection we saw staff using tailored communication techniques to ensure information was appropriately conveyed to people so that they understood what was being asked of them. For example, we saw staff observing people's body language as a way of determining if they consented to care and treatment and information was provided in pictorial and easy read formats for people.

Requires Improvement

Is the service well-led?

Our findings

Although the manager had made improvement regarding medicines administration practices; we found areas during our inspection where improvements were still required.

We found audits were undertaken in a range of areas including health and safety, infection control and medicines. We reviewed these audits and found that although they were thorough; appropriate action had not always been taken. For example; food charts were not completed accurately with specific details regarding people's diet options provided as recommended by SALT. Foods documented were not in keeping with the person's risk assessment and care plan. The registered manager agree to address this.

On the day of inspection the registered manager was a visible presence throughout the home. People who used the service, their relatives and staff spoke positively about the way the home was managed and how approachable the registered manager was.

One health professional spoken with said, "Without a doubt, across the board, this is the best home I visit. The home is worth its weight in gold." "It's a well- run home. The manager is hands on and visible in the home. Staff are always busy and never on their mobile phones." The other health professional said, "It's a brilliant home."

We asked staff about the management of the service. Staff said; "I love working here. I've worked here for years; it's a well led and well run home. The morale is good; the manager keeps the team going."

Staff spoken with said, "The management is very supportive and understanding. They are easy to talk to, their door is always open and I feel that I could go to them at any time." "The manager lets us know what's happening. We can discuss things openly and we get on with the job."

We saw staff were kept informed of any changes in policies, procedures or work practices through attending staff meetings. Staff told us, "We have meetings regularly and we are encouraged to have our say. The manager's door is always open. They really are there to help and support us all." "We have the team meeting once a month, two days after the residents' meeting so we can discuss what has arisen at the residents' meeting in our meeting." For example if a person required more attention or the best way of calming/reassuring someone.

We asked people if they were meetings where they could share their views about the service. One person said, "I know about them but I never go". Three other people said they knew about the meetings and had attended. We saw notes of the meetings held for people who used the service. Topics discussed included food, activities, safeguarding and the opening of the new unit.

Providers are required by law to notify the CQC of significant events that occur in care settings. This allows the CQC to monitor occurrences and prioritise regulatory activities. We checked through records and found the service had met the requirements of this regulation. It is also a requirement that the provider displays

the quality rating certificate for the service both in the home and on their website if they have one and we found the service had also met this requirement.

The manager told us as part of the quality assurance monitoring process the service sends survey questionnaires to people who used the service, their relatives as well as health professionals to seek their views and opinions on the care and support provided. The manager confirmed that once received, the information obtained is collated and an action plan formulated to address any concerns or suggestions made.

The service has established good working relationships with agencies involved in people's care and sharing good practice was continuously being developed. We saw records of meetings held with pharmacy, GPs local authority and CPA.