Burlington Care Limited

Southlands

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

This inspection took place on 9 July 2015 and was unannounced. We previously visited the service on 19 September 2013 and we found that the registered provider did not meet one of the regulations we assessed. This was in respect of the management of medicines. We carried out a further inspection on 13 December 2013 and found that the provider had taken appropriate action and the regulation had been met.

The service is registered to provide personal care and accommodation for up to 48 older people, some of whom may be living with dementia. On the day of the inspection there were 44 people living at the home. The home is located in Hutton Cranswick, a village close to Driffield, in the Riding of Yorkshire. It is close to village amenities and on good transport routes.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 3 June 2014. However, just prior to the inspection we were informed that the registered manager was due to retire during the week of our inspection. A new manager had

Summary of findings

been appointed and was due to start at the home on 13 July 2015. 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.

People told us that they felt safe living at Southlands and we saw that the premises were being maintained in a safe condition. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they would not hesitate to use the home's whistle blowing policy if needed. However, we saw some poor practice on the day of the inspection. For example, one person was seated in a wheelchair throughout the day that did not belong to them and did not support their posture correctly. This was not recognised by staff and had to be pointed out by the inspection team.

People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct authorisations had been applied for.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. The training record evidenced that most staff, including ancillary staff, had completed training that was considered to be essential by the home.

Some concerns were raised by people who lived at the home and staff about staffing levels. This had been acknowledged by the registered provider and the home was in the process of recruiting additional staff to cover for staff absences. We observed there were occasions when people had to wait too long for assistance and this caused them distress.

New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with older people had been employed, although there needed to be clearer evidence that all safety checks had been received prior to people commencing work.

Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust. Staff who had responsibility for the administration of medication had completed appropriate training.

People's nutritional needs had been assessed and people told us that their special diets were catered for. We saw there was a choice available at each mealtime. Most people were satisfied with the meals provided, although some people commented that menus were 'repetitive'.

People told us that staff were caring and this was supported by the relatives and health care professionals who we spoke with. There were systems in place to seek feedback from people who lived at the home, relatives and staff. We saw that people's comments and complaints were responded to appropriately.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by managers were designed to identify any areas of improvement in respect of care planning, medication and accidents / incidents. We saw that, on occasions, the outcome of surveys, audits and complaints were used as a learning opportunity for staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service is not always safe.

Staff had received training on safeguarding adults from abuse and moving and handling, and the arrangements in place for the management of medicines were satisfactory, although we had some minor concerns.

Some concerns were raised about staffing levels and more staff were being employed to ensure that the rota could be fully covered during staff absences. However, on occasions we saw that people had to wait too long for assistance and this caused them some distress.

We found that staff were recruited following safe policies and procedures, although there needed to be a more robust audit trail to evidence this.

Requires improvement

Is the service effective?
The service is effective.

We found the provider to be meeting the requirements of the Deprivation of

Liberty Safeguards (DoLS) and appropriate applications to authorise deprivation of liberty had been made to the local authority.

Staff undertook training that equipped them with the skills they needed to carry out their roles.

People's nutritional needs were assessed and met, and most people told us they were happy with the meals provided by the home. People told us they had access to health care professionals, including dieticians, when required.

Good

Is the service caring?
The service is caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

People were encouraged to be as independent as possible, with support from staff, and people's individual care needs were understood by staff.

Good

Is the service responsive?
The service is responsive to people's needs.

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for their care were recorded and these were known by staff.

Good

Summary of findings

People were able to take part in their chosen activities and their visitors were made welcome at the home.

There was a complaints procedure in place and we saw that any complaints received by the home had been dealt with in a satisfactory manner.

Is the service well-led?

Good

The service is well led.

The management arrangements at the home were satisfactory.

There were sufficient opportunities for people who lived at the home, relatives and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that the systems in place were being followed by staff to ensure the safety and well-being of people who lived and worked at the home.

Southlands

Detailed findings

Background to this inspection

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

The inspection took place on 9 July 2015 and was unannounced. The inspection team consisted of two adult social care (ASC) inspectors 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. The expert-by-experience who assisted with this inspection had a background as a professional nurse and of working with vulnerable people.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the registered provider and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they have had with the home and we received feedback. We also requested information from three social care professionals but we did not receive any feedback.

On the day of the inspection we spoke with ten people who lived at the home, five members of staff, five relatives, two visiting health care professionals, the 'acting' registered manager who was also the general manager for the organisation and the registered provider.

We observed the serving of lunch and looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for five people who lived at the home, the recruitment and training records for three members of staff and other records relating to the management of the home.

Requires improvement

Is the service safe?

Our findings

We spoke with people who lived at the home and chatted to others. We asked them if they felt safe and they told us that they did. This view was also supported by the relatives who we spoke with. One relative said, "(My relative) couldn't be in a better place, she seems content. She's safe from every aspect." We observed that people were able to move around the home and the enclosed courtyard without restriction. There was a code on the door to the grounds but people were able to go out without support if they had the capacity to do so.

We saw that all care staff and ancillary staff had completed training on moving and handling during 2014 / 2015. On the day of the inspection we saw staff using safe moving and handling techniques and saw that appropriate equipment was used when staff assisted people with transfers. However, we saw that one person had been sitting in a wheelchair all day without staff checking they were comfortable and safe. When we pointed this out to staff, they told us that the person was sitting in the wrong wheelchair; they required a specific wheelchair to support their posture. The person had also been incontinent of urine which indicated that they had not been offered support with their continence needs sufficiently during the day.

We saw that care plans listed the risks associated with the care of the individual person. We saw risk assessments for the risk of falls, bathing, being cared for in bed, going on outings, allergies, moving and handling and the risk of abuse. The level of risk had been identified and risk assessments were reviewed on a regular basis to ensure they were up to date and still relevant to the person concerned.

Care plans described any behaviours that might place the person at risk of harm from other people who lived at the home, and how these situations should be managed by staff. On the day of the inspection we observed staff were able to distract people in a patient and gentle way to keep them safe.

We spoke with the local authority safeguarding adult's team prior to the inspection and they told us about two safeguarding alerts they had received in respect of Southlands in March and May 2015; neither of these had progressed to an investigation.

Training records evidenced that all care staff had undertaken training on safeguarding adults from abuse during 2014 or 2015. In addition to this, all but two of the domestic staff had also undertaken this training. The manager told us that staff were expected to undertake this training every three years to ensure that their knowledge remained up to date. The staff who we spoke with were able to describe different types of abuse, and they told us that they would report any concerns. The registered provider told us in the PIR document that staff were reminded about the whistle blowing policy in supervision and staff meetings, and staff told us that they would use the home's whistle blowing policy if needed.

The registered provider told us in the PIR document that they continually monitored and updated staff rotas to ensure there were sufficient numbers of staff on duty. On the day of the inspection the manager explained the standard staffing levels; this was five staff plus a senior care worker on duty each morning, four staff plus a senior care worker on duty each afternoon / evening and three staff on duty overnight. In addition to this, there was a team leader on duty each day, Monday to Friday. There were plans in place to increase this to include Saturdays and Sundays. There was also an activities coordinator in place from Monday to Friday. We checked the staff rota for the previous week and this indicated that staffing levels had been maintained. We also saw that there was always a staff presence in communal areas of the home.

There was an administrator and an activities coordinator working Monday to Friday and ancillary staff, including domestic assistants, laundry assistants, cooks and kitchen assistants were employed each day. The cook prepared tea and it was served by one of the kitchen assistants. This meant that care staff were able to concentrate on supporting people who lived at the home and not on domestic or catering duties.

Two health care professionals who we spoke with told us that they could usually find a member of staff to assist them; one person said, "There is always someone around." Throughout the day we saw staff assisting most people in a caring and supportive manner so that they remained safe from harm. However, we noted that call bells were not always responded to promptly and towards the end of the day one person requested assistance to go to the toilet and we noted that they waited a long time for staff to help them, which caused them some distress. A relative told us

following the inspection that they had seen a person in a wheelchair become distressed as they were 'trapped' and could not independently negotiate their wheelchair; several members of staff walked past and it was about 15 minutes before a member of staff assisted the person to safety.

People who lived at the home told us, "I didn't get a bath last week. I think they were short of staff" and "I don't think there are enough. Staff are rushed off their feet. The staff don't talk about that in front of people but we have eyes in our heads." We discussed this with the acting manager at the end of the inspection and they acknowledged that there had been some occasions when the shift was "One person down". They told us they were in the process of recruiting additional staff to ensure that they could cover absences due to sickness or annual leave. One person was due to start work during the week of the inspection and another person was due to start their induction training. Another three staff were "in the pipeline". This evidenced that the organisation had recognised the need to recruit additional staff and had taken action to increase staffing levels.

The registered provider told us in the PIR document that they had a robust recruitment procedure at the home and that prospective employees were interviewed by two members of staff. We checked the recruitment records for three new members of staff. We saw that people submitted an application form that included their employment history, the names of two employment referees and a declaration about any criminal convictions. We noted that the questions asked at interview and applicant's responses were kept for future reference, along with evidence of the person's identity. We saw that the two employment references and Disclosure and Barring Service (DBS) first checks had been obtained before people started to work at the home. However, DBS checks for some people had been received after their start date; the manager assured us that people did not commence work on the staff rota until their DBS check had been received. They told us that, in the interim period, people would attend induction training or shadow experienced staff, but would not work on the staff rota. It was acknowledged that this information needed to be clearly recorded to ensure there was an audit trail to evidence that only people considered suitable to work with older people had been employed, and that this information had been received prior to people working unsupervised.

We saw that there was a contingency plan in place that advised staff about the action to take in the event of a power failure and included information about where people could be relocated in the event of an emergency. In addition to the contingency plan, people who lived at the home had personal emergency evacuation plans (PEEPs) in place. These are documents that record the assistance a person would need to be evacuated from the premises, including the equipment they used to mobilise and the level of assistance they would require from staff.

There were checks in place to ensure that the premises were maintained in a safe condition to protect the well-being and safety of people who lived and worked at the home. We reviewed a selection of maintenance certificates and saw that there was a current gas safety certificate in place and an electrical installation certificate that was valid until October 2015. The fire alarm system and emergency lighting had been serviced in March 2015 and there were also current service / test certificates in place for portable appliances, the passenger lift, mobility hoists and bath hoists. On the day of the inspection we observed that one person's call bell was disconnected. We re-connected the bell and it appeared to malfunction. This was reported to staff and rectified on the day of the inspection.

We saw the records of accidents and incidents. The records showed that any accidents had been analysed, including the seriousness of the accident and the action that had been taken, for example, whether medical attention had been sought. Any injuries or bruises were recorded on body maps so that staff were able to monitor their progress. However, we also noted that the reason the injury had occurred and the date it had occurred was not always recorded on body maps.

We saw that senior staff audited the medication systems each week and then they were audited periodically by the manager; an action plan was produced and reviewed at the time of the next audit. None of the people who we spoke with on the day of the inspection expressed any concerns about the administration of medication and they said they received their medication on time.

We checked medication administration record (MAR) charts and noted that there were no gaps in recording and that codes were used appropriately. Each person had a laminated sheet to accompany their MAR chart. This recorded the person's date of birth, their room number, any

Requires improvement

Is the service safe?

known allergies and included a photograph to aid identification. We noted that some MAR charts had come loose from the folder and there was a risk they could be lost; this was fed back to the acting manager on the day of the inspection.

We noted that care plans did not include details of behaviours that would indicate a person was in pain when they were not able to verbalise this. The senior staff member told us that they planned to introduce a separate sheet to record details about "As and when required" (PRN) medication, including pain relief medication. There was already a good practice procedure in place to ensure the safe administration of Warfarin. People who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered.

All staff who administered medication at the home had undertaken appropriate training, including night staff. We observed the administration of medication and saw that this was carried out safely; the senior staff member did not sign MAR charts until they had seen people take their medication. People were provided with a drink of water so that they could swallow their medication.

There was an audit trail that ensured the medication prescribed by the person's GP was the same as the medication provided by the pharmacy. The senior member of staff told us that these checks had identified errors in the past and that this gave them the opportunity to rectify the error and make sure that people received the right medication.

Medication was supplied in a bio dose system; this is a monitored dosage system that can store both solid and liquid medication in 'pods'. These can be removed from storage individually so that medication can be administered directly to the person concerned. There were two medication trolleys at the home and they were locked and stored in the medication room when they were not in use. The medication fridge was stored in the medication room. We saw that the temperature of the fridge and medication room were checked and recorded each day, and were consistently within recommended parameters. There was a suitable cabinet in place for the storage of controlled drugs (CDs) and a CD record book. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in use balanced. There was evidence in the CD book that records and medication was audited on a regular basis.

There was an effective stock control system in place but we noted that the date was not written on the packaging of tablets, creams and liquids to record when it was opened; this was needed to ensure that medication was not used for longer than stated on the packaging. We checked the records for medicines returned to the pharmacy and saw that these were satisfactory; a specific returns book was being used that recorded details of the medication to be returned.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. Care plans recorded when DoLS applications had been submitted to the local authority for consideration, indicating that managers understood the principles of the MCA and when it was appropriate to submit a DoLS authorisation form to the local authority.

Training records evidenced that nine of the 29 care staff had completed training on MCA and DoLS; this was considered to be 'optional' training for staff rather than mandatory. However, training on dementia awareness was considered to be essential and we saw that all but four care workers had completed this training. In addition to this, five ancillary staff had also attended training on dementia awareness.

Care plans recorded a person's capacity to make decisions and also whether they had a representative appointed to act on their behalf, such as a lasting power of attorney or enduring power of attorney. We saw evidence of decisions that had been made in a person's best interests when they lacked the capacity to make important decisions for themselves. One person's care plan recorded, "(The person) does not have capacity. Is supported to make basic every day decisions and would need other decisions to be made via best interest."

However, in one person's care plan we saw a 'Do Not Attempt Resuscitation' (DNAR) form. This recorded that it needed to be reviewed in March / April 2015 and there was no record that a review had been carried out. This was raised with the acting manager at the end of the inspection and they assured us this would be followed up with the person's GP.

People told us that their consent was sought verbally in respect of assistance with personal care and other care tasks, but they could not recall signing consent forms. The only consent forms we saw in care plans were in respect of photographs being taken of the person. It was not clear whether this was about photographs to use on medication records and in care plans, or as photographic evidence in the event of an injury, accident or safeguarding event. This needed to be made clear on the consent form.

We saw that corridors were spacious and ramps were provided to enable people to access the attractive outside spaces. We asked people what they thought about the layout of the home. One person told us, "Now I've got used to it. When you're walking round there's a good view of everything" and another said, "Yes, I find my way around alright. I walk, walk, walk." A relative told us, "Staff are very good at guiding people around. The layout is so good – no dangers. It's a beautiful setting and the staff go out of their way to make people feel at home."

The organisation had introduced a new induction programme. Staff attended three classroom days and worked ten days supernumerary and seven days shadowing experienced staff before they commenced work unsupervised. Training records indicated that two staff from Southlands were attending a three day induction training course on 6, 7 and 8 July 2015.

The acting manager told us that the organisation considered training on fire safety, moving and handling, infection control, safeguarding vulnerable adults from abuse, dementia awareness, medication (senior staff only) and health and safety to be mandatory. Records evidenced that most staff had completed this training. There was a record of whether the training needed to be completed every two or three years. Optional training included healthy eating and food hygiene (although no staff had completed this training), diabetes / falls, basic life support, first aid, food hygiene, MCA / DoLS and person centred planning. Sixteen current members of staff had attended training on first aid, diabetes / falls and basic life support. Records showed that there were plans in place for two or three staff from the home to attend training on first aid and food hygiene in July 2015 and for five staff to attend training on first aid in August 2015.

People who lived at the home and relatives told us that staff had the skills to carry out their roles. One person said, "The few I see regularly seem to have the skills. But, I'm sure all the staff have changed since I've been here." A relative told us, "Very much so. They know how to look after

Good

Is the service effective?

(my relative) – they're well informed." However, another relative told us that staff did not always have the skills to recognise changes in people's abilities and to meet their deteriorating physical and mental health needs.

Staff told us that they were well supported by managers. One person said, "You can speak to management any time." The registered provider told us in the PIR document, "Supervisions and appraisals are vital in ensuring one to one chats where issues are discussed and sorted, support and praise given and to iron out any niggles or poor conduct." We were told that the organisation had appointed a staff advocate. It was hoped that this person would be able to support staff with any problems they had, and that this in turn would result in a more positive working environment for staff. Staff who we spoke with confirmed that they could raise any issues in formal supervision meetings.

We saw that care plans included details of a person's medical conditions and any special care needs they had to maintain their general health. Information about some health care conditions was included in care plans to ensure staff were aware of the person's specific needs. People's assessments and care plans were reviewed on a regular basis to ensure that there was an up to date record of their current health care needs.

There was a record of any contact people had with health care professionals. We saw information recorded about referrals to and visits from dieticians, district nurses, GPs, the falls team and occupational therapists. The records usually, but not always, included the date, the reason for the visit / contact and the outcome. We saw advice received from health care professionals had been incorporated into care plans. Details of hospital appointments and the outcome of tests / examinations were also retained with people's care records. Health care professionals told us that they had a good relationship with the registered manager and staff. One health care professional told us they had encouraged staff to ask for advice, and they said that 95% of the time their advice was followed. Another health care professional told us that staff asked for their advice and followed it. We asked people who lived at the home if they were able to access their GP or other health care professionals when they needed them and they all responded positively, although one person told us that they used to see the physiotherapist but this had ceased. We discussed this with the acting manager on the day of the inspection.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are unable to verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs. This meant that hospital staff would have access to information about the person's individual needs.

We saw that care plans recorded any special dietary needs and that, when concerns had been identified about people losing or gaining too much weight, advice had been sought from a dietician and that this had been incorporated into care plans. However, we noted that advice provided by the dietician had not always been followed. For example, one person's care plan stated that they should be weighed every two weeks but there was no record of them being weighed since 4 June 2015. Food and fluid charts were being used and people's weight was being recorded, but this was not consistent. This could have resulted in risks associated with poor nutrition being missed.

People's specific dietary requirements and preferences were known to staff, including the chef. The chef told us that they met with people when they first moved into the home to discuss their personal preferences. The chef told us, "All the food is enriched for those residents where there aren't dietary restrictions. For those who need a special diet, I am provided with the necessary details following discussions that take place between the team leaders and the dietician. I then put that into practice – it might be dietary supplements, different textures or finger foods." However, one relative told us that staff did not seem to be aware of their relative's likes and dislikes in respect of food, even though they had lived at the home for some time.

People who lived at the home told us they were happy with the food provided. One person told us, "They have a very good cook. There's a good choice. I think they know what I like" and another person said, "I'm very seldom unhappy. You get a choice – if you don't like it they'll find you something else. It is the same all the time though." Other people mentioned to us that the menu was repetitive. We were told that there was a four week menu in operation

Good

Is the service effective?

that was devised by the organisation, with little input from the chef or people who lived at the home. However, the chef told us that the menu was discussed regularly at resident meetings and the feedback was generally good.

The mealtime was promoted as a pleasant experience. There was a menu on display that recorded the choice of meal on offer at lunchtime and teatime. On the day of the inspection the choice at lunchtime was either savoury mince, potatoes and vegetables or chicken and mushroom pasty. The choice at teatime was jacket potatoes with cheese, soup or sandwiches. We were told that staff spoke with people a few hours before lunch to explain the choices on offer.

A relative told us that they had seen people being seated in the lounge in preparation for lunch as early as 11.00 am; specific training on nutrition (especially for people living with dementia) may have helped staff to recognise that this was inappropriate.

Staff had undertaken training on food hygiene and we saw that the home had been awarded a score of 5 (the highest score on a scale of 1 - 5) in respect of food hygiene. This was following an inspection by an Environmental Health Officer working for the local authority.

Good

Is the service caring?

Our findings

People who lived at the home told us that staff cared about them. Comments included, "Yes, I like to think they do – they're very kind and do anything for me…….. they're lovely", "I feel cared for. They check to see I'm alright, morning and night" and "Most of them really care. We're fond of them and it works both ways." A relative told us, "They certainly do. I've not met anyone who isn't happy with the staff or the place generally", another relative said, "The staff have always been spot on here" and a third relative told us, "The staff are second to none." One relative told us that they had observed staff to be very patient and that they were able to distract their relative when they were unsettled. Both health care professionals who we spoke with told us that staff genuinely seemed to care for people who lived at the home, and said staff were aware of people's individual needs.

We observed positive interactions between people who lived at the home and staff throughout the day. We asked people if their care was centred on them, and they responded positively. One person said, "Yes, it's about what I need. I'm very happy here" and another told us, "I think my care is just for me." Some people said that they had been consulted about their care but others could not remember being consulted, although one person told us, "They do talk to you about your care."

Most people told us that staff shared information with them appropriately. One person said, "Yes, they're very good. They take the time to tell you things properly" and another said, "They give it to you in a very friendly way – just right. They give you the time and they listen to you too." However, one person told us, "What I know comes mostly from picking it up from the carers but there's no official information. They don't even tell us when someone has died" and another person said, "We do not always know what goes on here. We talk about it, exchange views with other residents about not knowing." We were aware that residents meetings were held and that a newsletter was produced; these systems may need to be reviewed to make sure that people who did not attend meetings were informed about what was discussed.

Staff told us that they read people's care plans and that these included information that helped them to get to know the person, such as their hobbies and interests, their family relationships and their likes and dislikes. On the day of the inspection we saw evidence to indicate that staff knew people's individual needs and wishes. However, one relative told us that staff did not seem to understand the signs when their relative needed to use the toilet, although the signs were quite clear to them.

A health care professional told us that when they needed to discuss people who lived at the home with staff, they were always knowledgeable about their needs. When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.

People told us that staff spoke with them in a friendly, polite and respectful way. The registered provider told us in the PIR document that, in supervision meetings, staff were reminded how to speak to people and not to talk about their personal issues at work and in earshot of people who lived at the home. They were advised that they should speak to people "How they would like to be spoken to themselves."

People who we spoke with told us that their privacy and dignity was upheld by staff and we observed this on the day of the inspection. There was only one shared room at the home meaning that most people had a private room where they could receive assistance with personal care or meet family, friends and health care professionals. However, one person told us that their bed was uncomfortable and this created them some distress. We shared this information with staff on the day of the inspection and were assured that this issue would be dealt with. Some people told us that the call bells were very loud and they found them to be intrusive. We noted that, because there were 44 people living at the home, the call bells did sound regularly during the day.

Good

Is the service responsive?

Our findings

Staff told us that they supported people to keep in touch with family and friends. People had access to telephones and relatives were able to visit the home at any time of the day. One relative told us, "I can visit anytime which is great." Another visitor told us that they had been provided with a separate room so that several family members could visit at the same time without disturbing other people who lived at the home. They had been invited to stay at the home for as long as they wished, and had been offered refreshments. People told us that they had visits from people living in the local community, including the church, and that they appreciated being able to keep in touch with local news and events.

One person told us that they would like to offer hospitality to their visitors. There was a coffee machine in a communal area of the home that had been provided for this purpose, but on the day of the inspection it was not working. The acting manager assured us that this would be repaired or replaced.

There was an activity coordinator in post who worked 30 hours a week. They told us, "There is a programme of activities for every day although we don't stick to it rigorously because it often depends on what people want to do. We do whist, dominoes, quizzes, bowling, dancing, sing-alongs and baking – quite a lot of ladies like to do that." They said they tried to organise activities that could take place outside, such as gardening, so they could take advantage of the lovely grounds and fresh air. A relative told us that activities at the home were excellent and that the activities coordinator was "Brilliant" and "There's always something going on." However, another relative told us they felt there was a lack of sensory stimulation for people living with cognitive difficulties.

Some people seemed to spend a lot of time in their rooms. One person said, "I don't do activities. I like to be left alone. I read a lot" and another said, "I don't join in. I like to go in the garden. I like reading and listening to the radio. Anyway, I can hear them singing in my room – they want to change the record." We asked the activities coordinator if they spent time with people who stayed in their room (if that's what they wanted). She told us that she spent one to one time with some people carrying out hand massages, manicures and chatting. She said, "I'll read with them or maybe look at books with pictures that remind them of things that mean something to them, or look at their photos."

The activities coordinator told us they had done training on dementia awareness and reminiscence as well as a National Vocational Qualification (NVQ) in Care, and that this had provided them with the skills they needed to carry out their role.

There were five lounge areas where people could spend their time. We were told by some people who lived at the home that the same groups of people congregated in the same lounge each day and that this had become 'cliquey'. It was not clear if people who stayed in their own rooms were encouraged to spend time with other people, and if people who lived at the home were encouraged to welcome newcomers. This was discussed with the registered person at the end of the inspection and they agreed it would be explored.

The registered provider told us in the PIR document that the activities coordinator met with people prior to 'resident' meetings so that they could act as their spokesperson if needed. They said they believed that relative and resident meetings enabled people to gain strength as a group and that at each meeting they fed back progress made since the previous meeting. People also told us that they were asked to express their views. One person said, "We have individual discussions. The person in charge comes round and asks if there's anything you want to talk about and how you're finding things."

The registered provider told us that they responded to any complaints promptly and that complaints were audited each month. We checked the complaints log and noted that complaints had been responded to in writing and that the person making the complaint had been asked to confirm they were happy with the outcome. There was evidence that appropriate action had been taken in response to complaints received, and that complaints were used as an opportunity for learning.

We saw that the complaints procedure was included in the home's service user guide, although the contact details for CQC were out of date. We did not see the complaints procedures displayed around the home. People who we spoke with told us that they were not sure how to make a formal complaint. However, they told us that they would be

Good

Is the service responsive?

quite happy to speak to someone if they had a concern or wished to make a complaint. Comments included, "I have nothing to complain about", "I've never had to but I'd go to the desk if I had one" and "I've never thought about it but I'd go to the top one." One relative told us, "Oh, I know there's an explanatory leaflet" and another relative told us that they had raised concerns and had felt these were listened to and acted on.

People told us that they had full choice in what happened to them at the home, and that their disabilities were taken into account. One person said, "I have a walking frame and I use the lift. If it weren't for these I wouldn't be able to get about" and another said, "My disabilities are taken into account by the aids I have and the space I have in the room so that I can get about."

No-one who we spoke with was familiar with the term 'care plan'. However, we saw that each person had a care needs assessment, a care plan and appropriate risk assessments in place. These covered topics such as mobility, moving and handling, eating and drinking, personal hygiene, skin care, medication, communication, memory / orientation, pain, end of life care and depression / anxiety.

Care plans were personalised and recorded who and what was important to the person concerned in a document called "All About Me." This included information about the person's hobbies and interests, their life history and their likes and dislikes. We saw that care plans and risk assessments were reviewed each month. In addition to this, we saw that more formal reviews of care plans were carried out both in-house and by the local authority. When more formal reviews were held, people who lived at the home were invited to attend these meetings to discuss their care and support needs. Care plans had been updated when needed and this meant that staff had up to date information to follow about the people who they were supporting.

Good

Is the service well-led?

Our findings

The acting manager told us that managers in the organisation used the CQC website to keep up to date with information about the adult social care sector, changes in legislation and good practice guidance. Both health care professionals who we spoke with told us that the home seemed to be well managed. They said that they had a good relationship with managers and staff, and that managers were "Very involved with service users." A member of staff told us, "(The registered providers) listen and the acting manager is approachable." They said that staff had expressed concerns about staffing levels; this had been listened to and more staff were being recruited.

We found the atmosphere at the home to be friendly and welcoming, and this was supported by the people who lived at the home, health care professionals and visitors who we spoke with. Comments from people who lived at the home included, "The atmosphere is very good. People feel welcome. We have people who come in who live locally, and some from the church" and "The atmosphere is good, no back-biting. Everyone gets on well together. People are welcomed locally – it's all open and people are encouraged to come." A relative told us, "The atmosphere is very friendly. It's always comfortable, helpful and safe. You can talk to the staff about anything. No-one is ever too busy." Many of the people who we spoke with told us they would recommend the home to others.

We saw evidence of satisfaction surveys that had been carried out in 2015; seven surveys had been returned by people who lived at the home and 29 had been returned by relatives. The survey asked questions about the atmosphere at the home, staff support, respect, decisions / choices, activities, privacy for visitors, cleanliness, menus, resident meetings and complaints. The surveys had been analysed and the overall outcome of responses was: 15% excellent, 71% good, 14% fair and 0% poor. An action plan had been produced to record any areas that needed to be improved. For example, "Staff to continue to ask people on arrival if they wish to see visitors in private." However, there was no record to evidence that some of the comments made by people, such as, "Would like more fruit and vegetables" and "Other people's clothes are often in her wardrobe" had been acted on.

The registered provider told us in the PIR document that they had regular senior and staff meetings to discuss "What we need to continue to do or change to meet residents' needs." We saw the minutes for the staff meetings held in February and May 2015. The minutes evidenced that people's needs were discussed and ways of improving communication between shifts was being looked at. The minutes also recorded the name of the "Employee of the month" and that they had received a £20 gift voucher.

We saw the minutes of 'resident' meetings that had been held in February and May 2015. These evidenced that the meeting was mainly used to update people on forthcoming events, but we noted that this information was not advertised on the home's notice board to ensure that people had a reminder; we noted that information on the notice board was out of date. There was evidence that suggestions made by people at these meetings were listened to and acted upon. One person had suggested that the organisation should rent a beach hut at the coast. This had happened and some people had been on trips to the beach and told us they had really enjoyed it.

Managers carried out a comprehensive audit to check that systems in place at the home were being followed and that people were receiving appropriate care and support. An audit carried out on 26 May 2015 covered the topics of finance, health and safety, fire, the control of substances hazardous to health (COSHH), first aid, reportable incidents, complaints, recruitment and retention, staffing, training, medication (incorporating a check on 10% of the bio dose system), assessment and care programmes, wound management, infection control, safeguarding vulnerable people from abuse and nutrition. The audits were carried out every one or two months, and included an action plan to record any areas that required improvement; some of the audits we saw recorded that no improvements were required but others recorded actions that were needed.

Individual audits were also carried out; we saw audits for medication, dignity, daily charts, meals and nutrition, and care plans, and there was evidence that these were carried out on a regular basis. There was a record of any actions that were needed to improve the service, although there was not always a record of when this work had been completed.

The registered provider told us that they had appointed a staff advocate. It was hoped that this person would be able to support staff with any problems they had, and that this in turn would result in a more positive working

Good

Is the service well-led?

environment for staff. A member of staff told us that the organisation intended to introduce mentor training to support new staff into their role. These two initiatives evidenced that the registered providers were proactive in making improvements to the experience for staff who worked at the home.

We noticed that the resident fire log stored in the foyer of the home also acted as an 'in and out' record for people who lived at the home. This was not up to date and did not record the number of people currently living at the home. We discussed this with the registered provider at the end of the inspection, and they agreed that the record either needed to be used consistently and accurately, or not used at all. The recording of food and fluid charts, body maps and weight records needed to improve. All other records that we saw on the day of the inspection were accurate, up to date and easily located by staff.