Gainford Care Homes Limited

Lindisfarne Newton Aycliffe

Inspection report

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Ratings

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

Overall summary

The inspection took place on 26 and 27 October 2015 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Lindisfarne Newton Aycliffe care home on 5 September 2013, at which time the service was compliant with all regulatory standards.

Lindisfarne Newton Aycliffe is a residential home in Newton Aycliffe providing accommodation for up to 56 older people who require nursing and personal care. There were 55 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager was on leave during our inspection but a deputising senior carer was able to assist us as we conducted the inspection, along with the regional manager and proprietor.

Summary of findings

We found the service to have comprehensive risk management processes in place, protecting people against a range of risks. The registered manager had undertaken unannounced night-time visits to the service to assure the safety of people who used the service.

Whilst there was a consensus that staff faced a challenging workload when there were unexpected absences, we found there were sufficient numbers of staff on duty in order to meet people' needs. All people and relatives agreed that staff were attentive and put the needs of people first. We saw call bells were responded to promptly and that staff were calm and patient in their interactions with people.

All staff were trained in core areas such as safeguarding, health and safety, moving and handling, infection control, person-centred care, mental capacity, as well as additional training tailored to the needs of people who used the service, for example dementia. Staff displayed a good knowledge of these subjects when questioned in detail. The service had a training matrix in place to track when staff had attended training courses and when refresher training was due.

We found that the management, administration, storage and disposal of medicines was safely carried out and adhered to National Institute for Health and Care Excellence [NICE] guidelines. Where we identified areas that could be improved the service responded promptly.

The service had a dignity champion in place and we saw regular observations across all floors had been undertaken. The outcomes of this process did not feature in staff meetings or management consideration and this was an area the service could improve on. A significant majority of people, relatives and healthcare professionals agreed that the service was effective in their management of people's healthcare needs.

All people who used the service we spoke with, relatives and visiting healthcare professionals agreed staff were caring.

There were comprehensive pre-employment checks of staff in place and effective staff supervision and appraisal processes, with staff confirming they felt supported by senior management.

The service was clean. We saw that a recent visit by an infection control team had raised no significant areas for improvement and that regular checks were in place to sustain high levels of cleanliness.

People told us they enjoyed the food and we saw that menus were varied and people had choices at each meal as well as being offered alternatives if they did not want the planned options. Mealtimes we observed were sometimes calm and unhurried although in one dining area the atmosphere was more hurried with loud music playing. We saw that the service had successfully implemented a tool to manage the risk of malnutrition and people requiring specialised diets were supported.

Person-centred care plans had recently been established and documents to ensure people's life histories, likes and dislikes were incorporated into their care planning. Regular reviews ensured people's medical, personal and nutritional needs were met. The service did not have a consistent approach with regard to involving relatives in these reviews where that was a person's preference, and this was an area they agreed to improve.

The service had an activities co-ordinator in place and a range of communal spaces suitable for group activities or for families to have quiet time with their relative. Not all people who used the service had their preferences considered or acted on and we found the service did not proactively plan activities with people's preferences in mind.

The service had a range of quality assurance, auditing processes and policies and procedures to deal with a range of eventualities. Emergency evacuation plans and maintenance of the premises were up to date.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The regional manager and staff we spoke with were knowledgeable on the subject of DoLS and we saw that appropriate documentation had been submitted to the local authority.

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?

Good

The service was safe.

People using the service told us they felt safe, whilst relatives and healthcare professionals told us they had never experienced any concerns with regard to safety.

The service had comprehensive risk management processes in place, protecting people against a range of risks. The registered manager had undertaken unannounced night-time visits to the service to assure the safety of people who used the service.

The management, administration, storage and disposal of medicines was safe and adhered to National Institute for Health and Care Excellence [NICE] guidelines.

Is the service effective?

Good

The service was effective.

All staff were trained in core areas such as safeguarding, health and safety, moving and handling, infection control, person-centred care, mental capacity, as well as additional training tailored to the needs of people who used the service, for example dementia.

The service had successfully implemented a tool to manage the risk of malnutrition and people requiring specialised diets were supported.

The regional manager and staff were knowledgeable on the subject of DoLS and we saw that appropriate documentation had been submitted to the local authority.

Is the service caring?

Good

The service was caring.

Care was delivered in a dignified and unhurried manner.

People who used the service and relatives described care that was compassionate and led by individuals' needs.

Communication plans were detailed meaning staff understood people with difficulties verbalising and people were likewise more able to engage with staff.

Is the service responsive?

Requires improvement

The service was not always responsive.

Not all people who used the service had their preferences considered or acted on with regard to planning and delivering activities that were meaningful to them.

Summary of findings

People's medical needs were responsively managed through the involvement of external healthcare professionals.

Care planning documentation and daily records were completed exhaustively, meaning other staff and external healthcare professionals had a clear history of care when supporting people.

Is the service well-led?

Good

The service was well-led.

The registered manager was involved in the day-to-day running of the service and had implemented an effective auditing regime to monitor the quality of the service.

Regular surveys sought feedback from people who used the service and staff. We found the feedback was largely positive.

The registered manager and other members of staff were working towards Gold Standards Accreditation with regard to providing end of life care.

Lindisfarne Newton Aycliffe

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.

We visited the service on 26 and 27 October 2015 and the inspection was unannounced. This meant the provider or staff did not know about our inspection visit. The inspection team consisted of one Adult Social Care Inspector and one Specialist Advisor. A Specialist Advisor is someone who has professional experience of this type of care service. The Specialist Advisor had professional experience of nursing and providing care for people living with dementia.

We spoke with eight people who used the service. We spoke with eleven members of staff: three carers, two senior carers, two nurses, one domestic assistant, the regional manager, the proprietor and the administrator. We spoke with six relatives of people who used the service. We also spoke with two visiting healthcare professionals.

During the inspection visit we looked at six people's care plans, risk assessments, five staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

We spent time observing people in the living rooms and dining areas of the home. We inspected the communal areas, kitchen, bathrooms, toilets and laundry.

Before our inspection we reviewed all the information we held about the service. We considered information shared with us by a local safeguarding and infection control teams, neither of which raised concerns regarding the service. We also examined notifications received by the CQC.

Before the inspection we did not ask the provider to complete a Provider Information Return (PIR). During this inspection we asked the provider to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make.

Good

Is the service safe?

Our findings

When asked about whether they ever had cause for concern one relative told us, "Oh no, it's very safe – I don't need to worry and neither does [Person]." One person who used the service told us, "No problems or concerns" whilst another stated they, "Felt safe" and had never felt at risk of harm. One person told us they had been concerned before moving to the service as they had always felt safe at home but that, since moving to the home they felt assured of their safety. All people we spoke with who used the service felt able to raise concerns should they need to and we saw that safeguarding information was clearly visible on entering the building, with established processes and contact numbers available should people or relatives need to contact external agencies directly. This meant people who used the service and their relatives felt safe but also that they were able to raise concerns should they need to.

Neither of the healthcare professionals we spoke with had concerns about the service in relation to keeping people safe. All relatives we spoke with were unanimous in their confidence in the service keeping people safe from harm.

Staff were consistently knowledgeable with regard to their safeguarding responsibilities following the relevant training. We saw that one recent safeguarding incident had been managed appropriately, with a range of other agencies involved promptly and a safe resolution for the people at potential risk. This meant the service knew how to act on safeguarding concerns and involved other agencies to ensure people were protected.

People who used the service, their relatives and staff we spoke with generally felt staffing levels were appropriate to provide for people's care needs. One person said "At odd times they seem understaffed," whilst some staff and a visiting healthcare professional told us there were times when staff found it difficult to complete all necessary aspects of their work. One relative told us, "I think staff are pushed but it doesn't have an impact on people." One visiting healthcare professional said, "Sometimes they might seem stretched but overall I would say the nursing and staffing levels are appropriate." During our inspection we observed people were supported promptly and call bells were answered without delay. We reviewed staffing rotas and saw the number and skills of staff were dependent upon people's needs and that staffing levels were appropriate. This meant, whilst people and staff felt staff were sometimes under pressure, people who used the service were not put at risk due to understaffing.

We saw specific risks to individuals were managed through risk assessments that were regularly reviewed and updated. Accidents and incidents were also monitored, reported and acted on. For example, one person's risk of falling had increased. We saw advice was sought from falls specialists and this advice promptly incorporated into care planning, alongside the use of specialist equipment to mitigate the risk. This meant the service had a structured approach to reviewing individual risks and was able to identify concerns at an early stage and mitigate those risks.

We reviewed a range of staff records and saw that in all of them pre-employment checks including enhanced Criminal Records Bureau (now the Disclosure and Barring Service) checks had been made. We also saw that the registered manager had asked for at least two references and ensured proof of identity was provided by prospective employees prior to employment. This meant that the service had in place a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

We found the service had systems in place for safely ordering, receiving, storing and disposing of medicines, including controlled drugs. Medicines records were maintained and medicines were stored safely in line with good practice. All medicines were within date and all recorded medicines fridge temperatures were within safe limits.

We sampled a range of Medicine Administration Records (MARs) and found no errors. We sampled controlled drugs and found there to be no errors in the storage of these. We saw, where people required medicines 'as and when', for example paracetamol pain relief, this was supported by a specific MAR and plans were in place to ensure staff knew when to administer these medicines. Body maps were in place to ensure staff administering medicines in a cream format knew how and where to apply these medicines.

We observed medicines being administered and saw safe practice was maintained throughout. We asked nursing staff about how they would deal with a variety of situations, such as refused medicines, and they evidenced a sound

Good

Is the service safe?

knowledge of medicines administration. We observed nurses communicating effectively with people and seeking consent before administering medicines. This meant people who used the service received medicines in a safe manner in line with National Institute for Health and Care Excellence [NICE] guidelines.

Maintenance records showed that Portable Appliance Testing [PAT] was undertaken recently, whilst all lifting and hoist equipment had been serviced, as had the boiler. We saw that fire extinguishers had been checked, fire maintenance checks were in date and the nurse call bell systems were regularly tested and serviced. This meant people were prevented from undue risk through poor maintenance and upkeep of systems.

We saw that disciplinary and whistleblowing policies were in place but that there had been no recent instances of whistleblowing or disciplinary procedures invoked.

With regard to potential emergencies, we saw that Personalised Emergency Evacuation Plans [PEEPS] were in place and easily accessible to the emergency services. These were detailed and highly personalised. For example, one person who had a military career and enjoyed marching on occasion had their PEEP written in such a way as to inform anyone helping them from the premises that they could be encouraged to walk by being asked to 'march' with people. This meant people could be supported to exit the building by someone who would have access to their individual mobility, communication needs in the event of an emergency.

With regard to infection control we saw that people's rooms were clean, as were all communal areas. Signage promoted the importance of hand hygiene and hand sanitiser dispensers were well positioned throughout the home. We saw that a recent visit from the local infection control team had identified no significant areas of concern, and had described the premises as "Immaculate". This meant the service managed and reduced the risk of acquired infections.

The Food Standard Agency (FSA) had given the home a 5 out of 5 hygiene rating, meaning food hygiene standards were "Very good." This meant people were protected from the risk of unsanitary food preparation.

Good

Is the service effective?

Our findings

Relatives we spoke with were all agreed that care staff understood the needs of people who used the service. One relative said, "They know [Person] and [Person] knows them." One person who used the service told us, "They really know what they're doing."

When we spoke with staff they were able to show a detailed knowledge of people's needs and in our observations we saw staff acting in accordance with care plans. We saw care plans were regularly updated and daily notes were extensive, meaning care colleagues and other healthcare professionals benefitted from a clear audit trail of care given and needs assessed. This meant people were supported by staff that had a good level of knowledge regarding their needs.

One external healthcare professional stated, "Staff are knowledgeable about people's needs," whilst another stated staff had sufficient knowledge and skills to ensure people's needs were met but questioned if they should always seek external support. The regional manager undertook to monitor this aspect of the service's liaison with external healthcare professionals to establish whether they were at risk of becoming too reliant on such support.

Staff we spoke with were knowledgeable in the areas they had received training in, for example when we asked them questions about their understanding of person-centred care and mental capacity. One senior member of staff told us, "The carers are a cracking bunch. The nurses and seniors wouldn't be able to do their job without them." We saw that training was relevant to people's needs, with all members of care staff having completed safeguarding, health and safety, moving and handling, infection control, person-centred care, mental capacity, as well as additional training tailored to the needs of people who used the service, for example dementia. We saw that staff who administered medicines were appropriately trained. When we asked staff questions about the subjects they had been trained in, they were able to give detailed responses to a range of questions about how the training influenced the care they gave. Staff told us they felt supported with the training arrangements in place. This meant people could be assured they were cared for by staff who had undergone relevant training and were able to apply that training.

One relative expressed concerns about the timeliness of referrals to healthcare professionals but when we looked into this concern there was no evidence to suggest the person's healthcare needs had not been effectively managed. We saw people were supported to maintain health through accessing external healthcare such as GP appointments, visits from the dentist, District Nurse visits, dermatology and respiratory specialist appointments. One person who used the service said, "I had a bad do the other night and they looked after me – they got the nurse and sorted me out." Another relative told us, "They do all they possibly can and make sure about [Person's] health needs." This meant the service ensured people's healthcare needs were met through effective liaison with external professionals.

One person told us that, prior to moving into the home they had needed to visit hospital on numerous occasions but since moving into the home this was extremely rare. They stated that this had had a positive impact on their wellbeing.

The service was using the Abbey Pain Scale, which is a means of helping to identify when people living with dementia are in pain but are unable to verbalise this. This meant people unable to communicate the fact they were in pain were observed via a method of recognised best practice to help identify whether there could be an underlying pain.

One member of staff said, "Support could be better," but the majority told us they received ample support to fulfil their caring roles. We saw that staff supervision meetings occurred regularly along with annual appraisals. Staff supervision meetings taken place between a member of staff and their manager to review progress, address any concerns and look at future training needs. This meant people could be assured they were cared for by staff who were adequately supported.

We observed positive interactions between staff and those we spoke with expressed confidence in other staff around them. One said, "We've got a good team here – dependable."

With regard to nutrition, one person told us, "There is always a choice of meals and if I didn't like something staff would find me something else." Other people and relatives confirmed that when the choice of meals was not satisfactory the cook would make something else. Another

Good

Is the service effective?

person told us they often had a sore throat and staff always ensured they had the option of ice cream as they found it soothing. One relative stated that they had visited during one lunchtime and found it to be, "Not a good dining experience," stating the quality of the food was not to a high standard. We asked a range of people who used the service and relatives about their dining experiences and all were broadly positive, citing choice and variety. With regard to the dining experience we saw the food served was hot and people we spoke with confirmed this was always the case. The dining experiences we observed during our inspection varied. The majority were calm and unhurried with people being supported where required in a dignified manner. We observed one mealtime that was less relaxed, with loud music coming from a television and no tablecloths in place. When we raised this with the regional manager they showed us that tablecloths had been ordered. This meant, whilst we observed one mealtime that could not be described as homely, the management of the home were in the process of addressing this.

In the kitchen we saw information regarding specialised diets and the need for supplements clearly displayed. Anyone noted as at high risk of malnutrition via the Malnutrition Universal Screening Tool (MUST), was supported with a fortified diet. MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. This meant the service effectively managed risks of malnourishment.

CQC 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). They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Where that freedom is restricted a good understanding of DoLS ensures that any restrictions are in the best interests of people who do not have the capacity to make such a decision at that time. The regional manager demonstrated a good understanding of Mental Capacity issues, including DoLS, as did members of care staff, who had recently been trained in this area. We saw that appropriate applications had been made to the local authority for people the service had identified as requiring a DoLS. This meant the service had implemented a sound understanding of the MCA and DoLS principals.

With regard to the premises, signage was clear and people's rooms benefitted from a picture outside their door. We saw there were memory boxes outside people's rooms. These were put in place so that people could have familiar memories outside their room, for example photographs. On a floor with 16 bedrooms we saw only three of these memory boxes contained anything. We asked the regional manager to address this.

We saw that people who had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision in place had been involved in the decision, as had family members and local medical professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. This meant people's needs had been reviewed appropriately with those who know them best.

Good

Is the service caring?

Our findings

People who used the service praised the staff who cared for them, stating, "They can't do enough for you – I have so much admiration for them," and, "I like living here – nothing is a trouble for them." One person told us how they had would prefer not to go into hospital to receive treatment because, they stated, "The care here is so good."

One relative told us, "They care so much – there are a couple of diamonds in there," and, "I always see plenty of interaction and they're always caring." Healthcare professionals we spoke with likewise commended the caring attitude of staff. During our inspection we observed numerous patient and compassionate interactions between care staff and people. For example, we observed a domestic assistant linking arms with one person who was slowly making their way to the dining area. The staff member, who was unaware of our presence, offered gentle encouragement and let the person take the lead. One member of care staff told us, "I know the standard of care here, that's why we brought [person] here." They had chosen the home for a family member who required residential care. This meant people who used the service could be assured that a staff member considered the care given to be to the standard they would expect a family member to receive.

One relative raised concerns about the levels of care not being to a high standard but, through our discussions with people who used the service, relatives, healthcare professionals, and based on the observations we made over two days on inspection, we saw comprehensive evidence of a caring service. This meant people were cared for in a dignified and compassionate manner.

People told us they felt content and welcomed in the home and a number of relatives commented on the approachability and compassion of all staff when they visited. One relative said, "There's always a welcome and there are some nice spaces where you can go and have a cup of tea with [Person]." This meant the service ensured people received the 'homely, sociable, friendly environment' outlined in its Statement of Purpose.

The service had a dignity champion in place and we saw they conducted regular observations on each floor of the service. The regional manager confirmed that this information was not currently used to champion aspects of best practice, for example through a standing item on staff meeting agendas, but agreed they would look into how best to share this information. This meant the service had some systems in place to ensure people's dignity was protected and would look into developing this aspect of the service.

We saw care plans contained detailed information where people's communication needs required additional support. For example, one person living with dementia was receiving doll therapy. Doll therapy involves giving a baby doll to people living with dementia as a means of providing a calming activity. We saw people who were receiving this therapy had detailed guidance, including using facial expressions and high levels of eye contact, written into their communication care plan so that staff were best placed to support them. This meant the service was aware of the need to communicate in non-verbal ways with people who may be unable to verbalise.

We saw information regarding advocacy services was available on noticeboards and in the Service User Guide, a copy of which was available in people's rooms. At the time of our inspection no one who used the service had an advocate but the regional manager displayed a sound knowledge of advocacy support available. This meant people's best interests could be supported through the service recognising the importance of advocacy services.

We saw people were asked about their religious beliefs when first moving to the home and that preferences were met through visiting clergy. This meant people's right to religious beliefs and freedoms were respected and enabled.

We saw people's confidential information, for example care records containing medical information, was securely stored in the manager's office. People who used the service were also asked for their consent for such information to be stored and, where appropriate, shared with other healthcare professionals.

Requires improvement

Is the service responsive?

Our findings

The pre-admission assessment in every care file we looked at documented people's life history through documents called 'This is Me' and 'Map of Life', which detailed likes, dislikes and a range of information regarding medical, dietary, religious, mobility and other needs. Each care plan we reviewed contained a photograph. We saw that care plans were reviewed monthly and a range of staff evidenced a good understanding of people's needs. We saw prompt external support had been sought when people's needs changed. We also saw specific information relevant to people's individual needs had been incorporated into care file documentation. For example, one person had a specific skin disease and we saw their care file contained detailed information about the nature of the condition and how best to support the person living with it. When we spoke with staff about this condition, they showed a good knowledge. This meant people's health needs were regularly assessed and consistently met.

We saw there had been some activities that were tailored to individual preferences and protected against the risk of social isolation. For example, a senior carer contacted the nearby army garrison and arranged for two soldiers from a tank regiment to present a birthday cake to one person who had previously served in the army in a tank regiment. This meant the service had considered what was meaningful to one person given their life history and tailored an experience accordingly.

We saw there was an activities co-ordinator in place but there had been concerns from people who used the service, relatives, and staff for a number of months about the range and extent of activities available for people. A recent meeting between the registered manager and activities co-ordinator had highlighted the need for more one-to-one time with people who used the service, as well as the need to arrange more outings. We asked people who used the service about this and one told us, "They don't do much co-ordinating of activities," and, "There's no outdoor time put on by the service." Another person stated that, "They do quizzes and bingo," and that they, "Can always find something to do." Relatives told us, "They don't facilitate mental stimulation," "They should actively pursue things for residents," and "Sometimes mental needs get overlooked a bit – not everyone wants to take that walk down memory lane and might enjoy doing something different." Another said "They could have a member of staff who just sits and chats with people." We also saw that, whilst all care files we reviewed had personalised information on file regarding people's preferences, some files had a blank Resident Social Care plan. We saw recent meeting minutes that acknowledged the need to complete these plans, as well as using the range of communal spaces available more.

Whilst the service facilitated a range of activities, we found there were no personalised activity plans in place taking into account people's preferences. This was an area the service agreed they needed to improve on.

The majority of people who used the service, relatives and healthcare professionals we spoke with were extremely complimentary about the responsiveness of the service with regard to people's healthcare needs. One relative said, "If anything changes they're on it very quickly." We saw the service routinely reviewed care plans as well as undertaking annual health checks. There was no consistent means of seeking input from relatives regarding people care plan reviews. We saw some relatives had signed a document to say they would like to be involved in care plan reviews but, when we asked if this had happened, the senior carer confirmed it had not. Relatives we spoke with confirmed they were content with their level of involvement, and were regularly contacted. This meant, whilst the provider did not routinely involve relatives in a formal review of people's care, communication was regular and relatives felt they were involved in people's care. The provider undertook to improve its facilitating of more formal relatives' involvement of care planning where this was requested.

We saw the service had a complaints policy in place and the manager had acted in line with this policy when complaints had been made to ensure any underlying issues were addressed and complainants were given full explanations. For example, one complaint had been regarding the mixing up of laundry. We saw this had been fully investigated and the solution of an additional general assistant employed to address ongoing pressures on this aspect of the service. Similarly, following a complaint regarding cleanliness being received, the registered manager increased the level of scrutiny in this area, undertaking weekend visits to the home and further spot checks to ensure the service sustained improvements in this area. We saw the complaints procedure was clearly

Requires improvement

Is the service responsive?

displayed in the Service User Guide in a large print format, supported by pictures. When we asked people who used the service and their relatives if they knew how to complain and who to they were confident. This meant people were supported to raise concerns, were confident in doing so, and that their complaints were handled professionally and fairly.

When people moved between different services each person had relevant medical and personal information photocopied so they could be afforded a continuity of care if they moved to another service for example if a person needed to go into hospital. The home was looking into using a standardised format to capture this information during our inspection.

Good

Is the service well-led?

Our findings

One relative told us, “The manager makes a point of speaking to everyone at least once a day. They’re not standoffish but very approachable. Very hands-on.” Another said, “The management and the staff are great,” whilst people who used the service confirmed they knew who the manager was, with one person describing them as a, “Nice lady.” One visiting healthcare professional told us, “The manager is fantastic.” Likewise the majority of staff we spoke with were positive about the level of support they received.

The registered manager was responsible for having oversight of all aspects of the service and had put in place a comprehensive auditing regime to assure safety, consistency and as a means of beginning to identify best practice. For example, we saw the registered manager had made spot checks at random times such as 3am and 4am to ensure that staff were providing appropriate and adequate care at a time when there was no management presence. We also saw care files were audited regularly, as was health and safety in the home, bed rails, dining experiences and mental capacity assessments. These audits had an evidenced impact on the standard of people’s care. For example, we saw one audit identified that one person had refused eye drops on a number of occasions; the audit was a means of bringing this to the attention of care staff and ensuring the matter was discussed with the pharmacy. This meant the registered manager completed comprehensive and effective audits of a range of aspects of the service to ensure quality standards were maintained.

The Service User Guide and Statement of Purpose outlined a service that was open to challenge and accountable to people who used the service and their relatives. People who used the service told us they felt confident discussing any concerns with any member of staff, whilst the majority of relatives we spoke with felt similarly assured on this basis and praised the detail and regularity of communications from the registered manager. One relative expressed concerns about the service not exploring flexible solutions in relation to one aspect of personal care and that, “With a little bit more direction it could be spot on.” We saw the registered manager held regular ‘surgeries’ with allocated time set aside for anyone who wanted to speak with them individually – relatives confirmed they had used this facility. This meant, whilst one person cited one instance where they were not content with the managerial response to their concerns, the majority of people, relatives and external healthcare professionals described an open, approachable and person-centred approach to management.

The registered manager was on leave during our inspection visit but the regional manager, proprietor and senior carer displayed a good working knowledge of the management of the service. When we spoke to staff about their awareness of senior management, they were positive about their visibility and approachability. During the inspection we asked for a variety of documents to be made accessible to us. These were promptly provided and well maintained. We found records to be easily accessible and contemporaneous. Policies and procedures were regularly reviewed by the registered manager and we saw the previous CQC report displayed in a communal area.

We saw that appropriate notifications had been made securely to CQC in a timely fashion. This meant people could be assured their confidential information was treated confidentially, carefully and in line with the Data Protection Act.

On arrival at the service we spoke to one member of staff who spoke positively about the current 15 minute handover process. We later saw the service was ending this 15 minute handover for all staff and replacing it with a handover for just nurses and senior carers. We asked whether this could have a detrimental impact on people’s care. The regional manager and proprietor provided assurances it would not and that they would monitor the implementation of the new handover system closely.

The registered manager, senior carer and one carer were attending a course to gain the Gold Standards Framework accreditation. Gold Standards Framework is a nationally recognised programme providing a framework for improving end of life care. This meant the service was exploring and acting on opportunities to improve its understanding of best practice in care.

Community links had been maintained by the registered manager, for example with a range of local charities and a sports club, who helped arrange regular events. The service

Good

Is the service well-led?

also took part in the recent National Care Home Open Day. This meant the service maintained links with the local community, enabling people to remain a part of that community.

The registered manager ensured surveys were sent to staff and residents. Recent responses from people who used the service showed that 13 out of 14 responded positively about the standard of care, whilst no significant concerns were raised. One survey suggestion had been the creation of a Resident's Charter and we saw that this had been implemented in the latest Service User Guide. This meant the registered manager involved people who used the service in ongoing considerations about how to improve the service.