Teesside Health Care Limited

Churchview Nursing and Residential

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

We last inspected Churchview Nursing and Residential Home on 6 September 2013 and found the service was not in breach of any regulations at the time.

Churchview Nursing and Residential Home is registered to provide accommodation for up to 47 older people who require personal or nursing care. Care is provided in single occupancy rooms on two floors, with nursing care provided on the first floor and personal care on the first floor.

Summary of findings

There was a registered manager in place at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has legal responsibility for meeting the requirements of the law; as does the provider.

The inspection visit took place over two inspection days, with the first day being unannounced.

There were policies and procedures in place in relation to the Mental Capacity Act 20015 and Deprivations of Liberty Safeguards (DoLs) The registered manager had the appropriate knowledge to know when an application should be made and how to submit one. This meant people were safeguarded. We found the service to be meeting the requirements of Deprivations of Liberty Safeguards.

People told us they felt safe. We found that the registered manager had appropriate systems in place to protect people from the risk of harm.

We found that people were provided with support and care by staff who had the appropriate knowledge and training to effectively meet their needs. The skill mix and staffing levels were also sufficient. Robust recruitment procedures were in place and followed, with appropriate checks undertaken prior to staff working at the service. This included obtaining references from the person's previous employer as well as checks to show that staff were safe to work with vulnerable adults.

Staff had the opportunity for ongoing development and the registered manager ensured that they received supervision, yearly appraisal and training relevant to their job roles.

People who lived at the service were encouraged to live fulfilling lives and it was clear from our observations that staff had developed good relationships with people. We saw kind and caring interactions and people were offered choices and had their dignity and privacy respected.

Good arrangements were in place to ensure people's nutritional needs were met. Where risks had been identified there was input from relevant healthcare professionals. People told us they were highly satisfied with the meal choices and quality.

People had their needs assessed and these were detailed within their care records, which were up to date and reflective of people's current needs. People's care records contained a good level of information and provided staff with the information they needed to effectively meet people's needs.

People had opportunities to be involved in a range of activities, which were influenced by their hobbies, interests and lifestyle preferences. We noted that people who lived at the service were able and encouraged to maintain relationships with their friends and family and enabled to take risks.

People were provided with information about concerns and complaints. We found people's concerns were responded to appropriately by the registered manager and there were systems in place to learn from complaints and incidents.

From the discussion we had with people who lived at the service, visitors, staff and other professionals, we found Churchview Nursing and Residential Home was a well led service. There were effective systems in place to monitor and improve the quality of the service provided. We saw the culture was one that took account of people's views and continually embraced improvement and development.

The service was accredited with Investors in People Award and also had beacon status for the Gold Standard Framework for end of life care.

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 who used the service told us they felt safe and protected. Staff had received training in respect of abuse and were clear about the action to take should they need to. Individual risks had been assessed and identified as part of the support and care planning process.

The manager and staff had completed training ins respect of the Mental Capacity Act 2005 and Deprivations of Liberties (DoLS). The manager understood their responsibilities under the Act.

There were enough skilled and experienced staff to support people and meet their needs. Safe recruitment procedures were in place, which ensured that only staff who were suitable to work in the service were employed. There were good staff support systems in place which gave opportunities for on-going development.

Is the service effective?

Good

The service was effective.

Staff received training appropriate to their job role, which was regularly updated. This meant that they had the skills and knowledge to meet people's needs.

People's nutritional needs were assessed and met. People had a choice of meals, which provided them with a well-balanced diet.

People had regular access to a range of healthcare professionals as need dictated, such as GP's, district nurses and dieticians. People were also supported to attend hospital appointments.

Is the service caring?

Good

The service was caring.

People were happy with the care and support provided to them. They spoke positively about the way in which staff helped them. Staff were kind and friendly and had developed good relationships with people.

People's independence was promoted and their privacy and dignity respected.

People's wishes for their end of life care were recorded and there were clear records to identify when people had 'Do Not Attempt Resuscitation' (DNAR) and Preferred Priority of Care (PPC) notices in place.

Is the service responsive?

Good

The service was responsive.

The service was responsive to people's needs. Their health, care and support needs were assessed and individual preferences discussed with people who used the service.

People's care records had been regularly updated and provided staff with the information they needed to meet individual's needs.

Summary of findings

Life history information was obtained and people had lots of opportunity to be involved in a range of social and recreational activities.

People were given the information about how to make a complaint and we saw that complaints had been responded to appropriately.

Is the service well-led?

Good 

The service was well-led.

We saw that the registered manager promoted a positive culture of openness and inclusion within Churchview Nursing and Residential Home.

There were effective systems in place to monitor and improve the quality of the service provided.

Accidents and incidents were monitored by the registered manager and the providers to ensure any trends were identified and lesson's leant.

Churchview Nursing and Residential

Detailed findings

Background to this inspection

The first inspection visit took place on the 15 July 2014. The inspection team consisted of one adult social care inspector, one inspection manager and an expert by experience who had experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The second inspection visit took place on 24 July 2014 and the inspection team consisted of one inspector.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. We also spoke with one of the commissioning team about the service and also with Healthwatch which is the consumer champion for health and social care.

We were provided with the provider information return (PIR) after the first site visit as the registered manager had not received the request for this information in sufficient time prior to the inspection. This is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was reviewed and used to assist with our inspection.

Throughout both of the inspection visits we spent time observing the interaction between people who lived at the service, visitors and staff. We also spent time looking around areas of the home including people's bedrooms (with their permission) and communal areas.

During the visit, we spoke with eleven people living at the service, six relatives, the registered manager, deputy manager, cook, assistant cook, administrator, senior care assistant, two care assistants, apprentice and the activities co-ordinator. At the time of the visit, there were 45 people living at the service.

We spent time looking at a range of records, which included the care records of six people who lived at the home, three people with nursing needs and three people with personal care needs. We also looked at staff records and records relating to the management of the home.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home. They said, "Yes we feel safe, if you are not very well or feeling a bit uneasy you ring the bell and they will come." And "I feel safe, well looked after, the staff have the skills and knowledge."

Staff who we spoke with told us they had received training in relation to abuse and safeguarding. Staff were all well able to describe the different types of abuse and the actions they would take if they became aware of any incidents. We looked at training information which showed that staff had completed training in regards to these topics and this training was current and up to date. This showed us staff had received the appropriate training, understood the procedures to follow and had confidence to keep people safe.

Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA) legislation which is in place to protect people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests and the least restrictive option is taken. The training information we looked at showed that staff had completed training in respect of these topics. Staff we spoke with were able to explain the process and how they liaise with the local authority.

We spoke with a care manager from the local authority who was a lead person for DoLS. They were confident that the staff had the knowledge and understanding about this topic. One person who lived at the service said, "We are well cared for and I can exercise my rights."

We looked at the care records for six people who lived at the home. We saw a range of risk assessments had been completed. These included risks associated with mobility, nutrition and skin integrity. We saw that these had been regularly reviewed and updated. Where risks had been identified clear plans were in place and where necessary, appropriate equipment was used to minimise potential risk. This included for example, moving and handling equipment, such as hoists.

The activities person (this is a person who arranges social events and activities) told us they work with people to ensure any risks associated with activities are identified. They described how they would involve the physiotherapist as needed to ensure safe practice. In one person's care records we looked at, we saw that they had been assessed by the 'falls team' (NHS team who gave advice on the prevention of falls), to ensure that they were able to participate in exercise classes safely.

The provider told us in the provider inspection return (PIR) that, "We will endeavour to liaise closer with families, loved ones and others involved actively in the care of clients to improve risk assessments and make them more personal to our clients. Including assessments for diabetics who are unwilling following appropriate diet advice. Residents who are prescribed Warfarin and the risks associated with its use and clients who have capacity and like to go out independently."

We saw that risk assessments had been completed and regularly reviewed for people who wanted to go out of the home on their own. In one person's care records we saw that an assessment had been completed for assessing risk and balancing quality of life and a clear plan was in place. It detailed, "To keep X safe, X's family are aware of the risks but are determined that he/she should have a normal and independent life as possible." There was evidence that regular reviews and updates of risk assessments had been completed.

We looked at the recruitment files of six members of staff. We did this to ensure the recruitment procedure was effective and safe. We found all staff went through a comprehensive recruitment process. This included completed application form and interviews and a Disclosure and Baring Scheme (DBS) check before the person started work.

One person we spoke with who lived at the service said, "I have been asked to be involved in the recruitment of staff and be part of the panel." The activities co-ordinator told us about the 'residents' panel for recruitment. The activities person talked of the importance of involving and empowering people.

We spoke with eleven people who lived at the home, six visitors and staff about the staffing levels and skill mix within the service. There were some contradictory views about the sufficiency of staffing. People we spoke with said, "There is sufficient staff and the bell is always answered promptly." "There is a consistency of staff – very little turnover. The staff are happy you can see that. You press

Good

Is the service safe?

the buzzer and they are here within seconds," and "Yes there is enough staff they are all excellent." Others said, "You do have to wait sometimes" and "They are generally pretty good but stretched, they do rush around."

We spoke with the registered manager and staff about staffing levels and skill mix and also looked at the duty rota, which detailed the staffing levels and skill mix described. One member of staff said, "Most of the time we are fully staffed, unless staff ring in sick." They confirmed that agency staff were used where needed and they tried to make sure it was the same agency staff, thus having knowledge of people, which provided continuity of care. Another member of staff said, "Staffing levels are sufficient to meet people's needs. If there is any sickness it is always covered by bank or agency staff" and "If I had any concerns about staffing levels I would raise these with the manager."

Another member of staff we spoke with said there were 10 members of nursing/care staff in total for both units during the day and this would change if people's dependency needs changed. They also said there would be three care staff and a senior care assistant on the upstairs unit and four care staff and a senior care assistant downstairs. There was also always a registered nurse on duty.

We observed medicines being given out during the morning and the staff member giving out the medicines was wearing an apron with "do not disturb" on which meant that they could concentrate on giving the medicines out in a safe manner. People were given their medication and assisted where needed and the member of staff stayed with the person until they had taken the medicines. An explanation was given to people of what the medication being administered was.

Good

Is the service effective?

Our findings

People had their needs assessed by the registered manager or deputy manager before they moved into the home. This assessment process identified people's needs and a decision was then made as to whether it was suitable to admit people to the home.

We looked at training information and found staff had completed training relevant to their job roles, which was up to date. One member of staff said, "The training is good, most staff have NVQ 2 and quite a lot have NVQ 3." "I definitely think the staff have the knowledge and understanding to meet people's needs and we would source extra training if needed." The training information we looked at also showed staff had completed other training which enabled them to work safely. This included fire, first aid and moving and handling training, which was regularly updated. We noted that if people had a particular diagnosis of a medical condition then additional information about the specific condition was contained within the person's care records. Example's included information about vascular dementia, dysphasia and atrial fibrillation. This gave staff additional underpinning knowledge about these conditions, which enabled them to support people in a more informed way. Staff said they received regular training, which was updated on a regular basis. They said the training also included client specific training, such as dementia care and depression.

We spoke to an apprentice who was working 30 hours in the service on a college placement. They had been going to the service for 3 weeks. They said that the first week was spent doing training and the second week engaging with people and doing activities with them. During the third week they had supported with eating and observing and doing moving and handling. They said they had completed training DVDs in infection control and abuse and when asked they said they would not tolerate any kind of abuse and would go straight to the registered manager or the person in charge. The person we spoke with said, "I really like it here and the care is delivered to a really good standard. I am always shadowed by a member of staff and never work alone." We observed this person being supervised by a permanent member of staff during the inspection visit.

The PIR detailed that additional training had also been arranged with the local Clinical Commissioning Group (CCG). This was intended to further improve staff skills to identify and spot the signs of; malnutrition, pressure sores, falls, incontinence and depression. It also detailed, "Regular supervisions and appraisals are carried out with an open culture to ensure personal training & development planning, staff feel supported and motivate to improve performance and services" and through workforce development programmes such as Skills for Care, Tees Valley Alliance and the Quality Service Framework, the outcome is improved practice at all levels around the Home. We saw evidence of this during the inspection.

Staff we spoke with told us they received regular supervision. They told us they received appraisals annually and supervision every one to two months and we saw evidence of this in the records we looked at. They also said that induction was completed over a three month period. The staff continued to say they could have a chat with the registered manager in their office anytime as it is an open door policy. Staff we spoke with told us that they were encouraged to continually develop. One member of staff discussed the support they were given which enabled them to be promoted into a senior care assistant role within the service. One member of staff said, "I feel valued and love my job, I would never think of going anywhere else."

We saw that staff had opportunities to attend meetings, which were minuted and made available to staff. We looked at some of the minutes and saw there were some general themes. These included employment law issues, code of conduct, dignity and respect, safeguarding and a number of policies and procedures. The last meeting detailed that an action point was to include in future meetings bullet points from the 'residents' forum.

We spent time in the lounge/dining areas observing the interactions between people living at the home and the staff. There was a very calm atmosphere in these areas. We noted there was constant staff presence. People came and went in the attached dining area and were enjoying breakfast which was toast and cereal and yoghurts were also available. A cooked breakfast was also available if people wanted it. Staff told us and we saw that breakfast was available until 10.30am. Other comments included, "You get too much food, when I was at home I used to have a small portion and at tea time would have toast or a light snack. Here you get two big meals; I am not complaining I just have a small portion. I like sprouts and I asked for them and I got them." Other people said, "The menu is

Good

Is the service effective?

marvellous, they have very good dinners." "The food is very good. You get a choice if you don't like it, you eat what you like. You can make a suggestion there is a good choice – there is always a dessert and they are very good."

Relatives we spoke with said, "He/she has a choice of food and if there is nothing she likes she can ask and they will accommodate."

We spoke with the cook who told us they had received training in food hygiene and safety and had completed a City and Guilds course. They knew which people had special diets because the chef (cooks line manager) knew and kept the staff informed. There was a list which was kept updated by the chef and the home manager. They said, "The menus are changed every week and are often changed if the weather is hot or cold or to meet individuals preferences." We saw the menus which were changed every week and there was a good variety of meals which included fresh vegetables. There was always a hot lunch offered and a lighter tea which was usually sandwiches and cakes but again alternatives were offered. We observed lunchtime and one person did not want a hot lunch and asked for sandwiches which were served shortly after. The kitchen staff we spoke to said the quality of food purchased for people was "Very good from Blackwell's butchers." They said that there were iced lollies available for people if it was hot and other choices that could be made whenever people wanted such as omelettes and sandwiches.

Nutritional assessments, including the Malnutrition Universal Screening Tool (MUST) was evidentin people's care records that we looked at. We saw people had their weight monitored and saw that these were regulary reviewed and up to date. We saw that where risks had been identified the service had consulted with the person's GP and there was the involvement of the relevant healthcare professionals, such as speech and language therapists. One person we spoke with said that their weight was being monitored and that they had an appointment to see the dietician.

We spoke to a visiting speech and language therapist who had visited the service a few times in the last few months and found staff were, "Friendly and followed our advice and they seem to know the residents well." They said that they only visited the nursing unit at the moment and see people who have swallowing difficulties or difficulties following stroke with choking or swallowing. They said that they wrote their directions/advice into people's care plans and this reduced the risk for people with difficulties.

We saw within people's care records that there was a 'medical services' sheet. We saw that staff had recoded when people had been seen by other professionals, including input from district nurses, falls team, chiropodist and social services reviews. We saw that service contracts were in place for equipment, such as bariatric equipment (equipment and supplies that are designed for larger or obese people) and specialist beds. There was regular liaison with social care teams, GP's, Macmillan's services, Hospice services and the district nursing services.

Good

Is the service caring?

Our findings

People we spoke with told us "I am very happy with the staff; they do treat me with dignity and respect. I have a good rapport with them." People we spoke with were extremely positive about the care they received at the home. They said, "It's fantastic in here. I am very happy with the care, it's excellent. The staff are very good. They always explain everything."

Relatives we spoke with also said, "They are marvellous in here, they give one on one, people are not just a number they are a person. The nurse always lets us know what is going on." They went on to say, "The staff deliver personalised care always." Another relative we spoke with said the staff were so accommodating with the person's spouse, as they liked to visit every day. They said that they had meals together and even had an afternoon nap in their room together. They also said their relative was going to be moved into a bigger room to accommodate their spouse visiting so much.

One member of staff we spoke with said, "It is a holistic approach to care and I think we have it just right." People who used the service were involved in choosing the 'carer of the month' and were also involved in the recruitment of new staff.

The provider told us in the PIR that 'Do Not Attempt Resuscitation' notices had been completed where necessary. Where a person had a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) notice in place, this was kept at the front of the person's care records and stated it was to be reviewed in 12 months. We saw evidence of DNACPR in care records we looked at and there was evidence of family and GP involvement in this decision. Staff we spoke with were aware of who had these notices in place and told us that further supporting information was available within the staff office.

Within the PIR it was also stated that preferred priorities for care (PPC) had been completed. The PPC is a document to write down what people's wishes and preferences are during the last year or months of their lives. The completed documents we saw included information about the person wanting to be involved in decisions, where they wanted to be if their death was imminent, for example in hospital or at the care home. The documents were signed by the person and family member, where appropriate. We saw these completed documents were available within people's care records we looked at during the inspection.

The service had recently developed the provision of a 'family room' for family and friends who might want to stay close by during significant life events. This was an overnight provision with meals and beverages provided.

The provider detailed in the PIR that a range of support was in place for end of life support to people and their relatives. This included, information leaflets in various formats including 'As we say goodbye' to provide information to families to help support loved one at the end of their life and 'what happens next' support & information about after care and bereavement.

At the time of the inspection the service were going through the re-accreditation process for the Gold Standard Framework (GSF) in End of Life Care. Following the inspection the registered manager informed CQC that they had been successful in continuing with this accreditation for GSF Quality Hallmark Award and had retained beacon status. To be recognised as a beacon, a home must show innovative and established good practice across at least 12 of the 20 standards. We saw from the care records of six people that we looked at that care planning was person centred (aims to see people as an individual with unique qualities, abilities, interests, preferences and needs). These records contained detailed information about people's needs and gave staff the information they needed to support people in the way they wanted to be supported. We spoke with staff about the people whose records we looked at. All had a very good understanding of people's individual needs and their lifestyle preferences. People we spoke or their relatives said they were aware of their 'care plans' that they had been involved with them and that reviews had taken place. We saw evidence of this in the records looked at.

There was a 'This is me' booklet in each of the care records, which contained very specific and personal information about the persons likes and dislikes and their personal needs for example, "Please don't stand in front of me while I am walking." There was also a detailed history of the person's life, past work and relationships past and present. Hobbies and interests were also detailed. This provided staff with information about people's lives, which assisted

Good

Is the service caring?

them in supporting people in a more holistic way. We reviewed documents which detailed consent to care and treatment and were signed by the person or a representative and covered medication also.

During the inspection we saw staff regularly referred to people's care records for information and to update them following care interventions or due to changes. This ensured the care people received was appropriately recorded and staff had the most up to date information about people's needs.

Throughout the inspection we observed staff treating people with respect and maintaining their dignity. One person asked to get up out of the chair and staff came promptly and assisted them into a wheelchair in a dignified and respectful manner. Another person was assisted by two staff into a hoist and then into a wheelchair. Reassurance was given by staff during the transfer as the person was anxious but quickly calmed down and was transferred without a problem. We observed another person calling staff as they wanted to go to the toilet. This was attended to immediately, with appropriate equipment used by two staff and good interactions between the person and staff.

Staff told us of the importance of dignity and respect. One member of staff said, "It is really promoted within the home. You have to remember that many of the people are from a different generation. We make sure that we deal with personal issues such as incontinence sensitively and discreetly."

Good

Is the service responsive?

Our findings

One person we spoke with told us, "Since being here I have been much more confident, so much more sociable, am eating better and am getting better." People we spoke with confirmed they could come and go as they pleased.

One relative we spoke with said, "Her care is personalised and when she has been unwell in the past they are really responsive making sure she has her fluids. We have told them her preferences as she is limited with her speech." "The manager is very approachable and she has a good relationship with mam, she will sit with her especially if she is distressed and will to find ways of dealing with her anxiety by using calming strategies. Overall it's a very good home."

We looked at care records for three people who lived on the nursing unit and three on the residential unit. All of the care records contained up to date information and accurately reflected the persons individual care needs. The information was personalised and there was evidence that people had been consulted and involved. We saw that staff worked with people in line with their care plans. This ensured they received care that was responsive to their assessed needs.

There was an activities co-ordinator who worked 9am until 4 pm during the week but also arranged activities in the evenings and at weekend and was flexible depending on the needs of people. They had access to the internet and Skype for people to use to contact their friends and relatives. Some people who used the service had phones or some used the home telephone if they needed to. A range of activities were arranged and included arts and crafts, bingo, dominoes, board games, discussion groups, reminiscence and pamper sessions. The activities co-ordinator had worked with people who used the service to come up with a 'wish list'. They then arranged for people to do things off their list. People said, "I have not tried everything there is to do. We have competitions. I like it and I would rather use my brain. X (activities co-ordinator) arranges all these things like memory lane." "We can vote on what to do, I like to read." We also saw a monthly newsletter was produced and detailed information about activities, any projects people were involved in, forthcoming birthdays and announcements and photographs of people being involved in different activities. We also saw that one of the people living at the home had their own editorial.

The activities co-ordinator told us that they had completed training in respect of meaningful activities and that they network with other activities co-ordinators to share information and increase knowledge. They said that they are continually researching information from both an activities perspective but also from the perspective of providing people with more rewarding and fulfilling lives. We saw within the activities room that there were signage that outlined some of the values associated to people, words included, purposeful, constructive, energise and self-worth. Local community involvement was also maintained with invitations and escorts to local events, trips out to local social clubs and escorts to family events. In addition, people had also been involved in a Stockton Borough Council project for rediscover Stockton and had made nominations for lucky stars on the walk of fame.

The activities co-ordinator and staff had recently looked at ways to communicate more effectively with people who were unable to verbally communicate. They had recently developed and introduced pictorial prompt cards. An example of this included a pictorial card for people who were feeling unwell, this enabled staff to engage with the person and gather more information about their specific symptoms.

Other activities included a weekly exercise programme that was delivered by a member of the NHS falls team. There was also other therapies delivered by external agencies including music therapy and Pet Therapy. Pet therapy is a guided interaction between an individual and a trained animal. It also involves the animal's handler. The purpose of pet therapy is to help a person recover from or cope with a health problem or a mental disorder. Pet therapy also is called animal- assisted therapy (AAT).

People living at the home had also been involved in work with the local university graphic design students to look at how the interior design of the home could be improved. Plans were underway to see how these ideas can be developed within the service.

People living at the home were provided with a 'resident's handbook'. This contained information about the home as well as information about making complaints. People living

Good

Is the service responsive?

at the home said, “I have the details of what to do if I wanted to complain in the folder.” “We would talk to the staff or go to the office if we had a complaint. We have had queries in the past but they have been sorted.”

The provider told us in the PIR that the service, “Listens to individual choice, preferences and encourage clients, families to be proactive with their opinions in the development and delivery of services to them.” It also detailed that care plans reflects the client’s choice and preferences including ‘This Is Me’. We saw evidence of these completed documents in the care records we looked at.

A ‘resident’ and relative satisfaction survey for 2013/2014 had been completed. There was a 50% response rate. A summary of findings and actions to be taken was completed and made available to people. We saw that where people had made suggestions for area of improvement, this had happened. An example included people saying they wanted two main choices at mealtimes as well as alternatives. We saw during the inspection action had been taken to address this and saw that people had the choice of two main meals.

We looked at the process for managing complaints and saw clear procedures in place. We looked at the complaints file and saw the complaints that had been received were robustly investigated and responded to appropriately. The registered manager detailed that, “We use feedback from the complaint to evaluate the service we provide by using a significant event analysis. We reflect on the event, establish what we could have done better and put strategies in place to enable us perform better next time.” One person said, “I am more than happy here. The staff are lovely, friendly, if you have any problems you just go to them.”

We also saw letters and cards received from families and friends acknowledging and thanking staff for the care and kindness shown to their loved ones and support given to the extended family.

Staff we spoke with confirmed that people living at the home were provided with information about complaints and had this available to them in their rooms. One member of staff said that if there were any lesson’s to be learnt these were discussed in staff handovers or in team meetings.

Good

Is the service well-led?

Our findings

The registered manager had been in post for a significant number of years and was registered with CQC. The registered manager was supported by a deputy manager and there was also regular involvement from the directors of the home who also had specific roles. The registered manager told us about the need for continuous improvement and development within the staff team. They described a process of succession planning that was underway for the deputy manager. We found the service was well led and both the registered manager and deputy manager promoted an open and positive culture within the service.

People we spoke with told us they had opportunities to attend meetings. They said, "They have regular meetings you can contribute and I am invited to" and "Yes there have been surveys and once per month I think the meetings are. I am very satisfied. It is all open and inclusive." We saw that the 'resident' forum meetings took place on a regular basis. These meetings are closed to staff; however the activities co-ordinator was in attendance and acted in an advocacy role. We looked at the minutes of the last three meetings, which were informative and also noted a good attendance at these meeting with an average attendance of 22 people. We saw other evidence of how people were involved about decisions within the service. An example included the involvement of people on the staff recruitment panels.

We looked at a sample of audit reports. These included audit of the medication systems, care records, mattresses, moving and handling slings and cleaning systems. Audits also included staff supervision and appraisal for which one of the directors was responsible for and for which action plans are developed. There were also monthly meetings between the registered manager and the directors.

The PIR detailed that the service was looking to further develop their internal quality assurance systems. During the inspection the registered manager showed us new documentation for care plan auditing, which the deputy manager was going to be responsible for.

An infection and prevention control audit had also been completed by an infection control nurse from the CCG in January 2014. The service attained 100% in this audit and a member of staff came first in a CCG Infection and prevention control award.

We saw that the registered manager had a robust system in place for monitoring accidents and incidents. We saw that individual accidents were reviewed by the registered manager and there was also a full monthly analysis separated into the nursing and 'residential' units. We saw through the analysis that the registered manager was able to identify trends and risks. We saw that where necessary connecting factors had been considered and actions taken to minimise further risks.

We spoke with staff about the culture within the home and they talked about openness and involvement. Comments made included, "It is a very open culture, X(the registered manager) door is always open." "It is a well-run home, X (the registered manager) is good and very approachable."

In terms of values, one member of staff said, "The residents are centre to the service; it is about promoting individuality and choice." Another said, "Flexibility, freedom, choice and it is all about the person." A further member of staff said, "We have visions and values and there is also a 'residents' charter, which everyone has had input into."

One member of staff said, "I feel really valued by management, residents and other staff." "It is a really well led and managed service and as a member of staff I feel listened to." Another said, "There is good communication and an open door policy."

A visiting professional said, "It is a well-run home, they have their fingers on the pulse and know what is going on. There is effective two way communication."

The service also has the Investors In People (IiP) Award which is valid until October 2016. IiP is a nationally recognised framework that helps organisations to improve their performance and realise their objectives through the effective management and development of their staff.