Meridian Healthcare Limited

Daisy Nook House

Inspection report

Bamburgh Drive
Ashton Under Lyne
Lancashire
OL7 9SX

Tel: 01613431033

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 24 October and was unannounced. This meant the provider did not know we were coming. Daisy Nook House was last inspected in June 2013. The service met all the regulations we inspected against at that time.

Daisy Nook House is a care home with accommodation for up to 40 people who require personal care, some of who are living with dementia. The service had three communal lounge/dining areas which contained a small kitchen so staff could access hot and cold drinks at any time for people. Each lounge area consisted of comfortable seating, occasional tables, TV and radio.

'A registered is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

Staff had been safely recruited with relevant checks completed prior to them starting work. Staff were provided with training to enable them to care effectively for the people they supported. Staff told us they felt supported by the registered manager and found them to be open and approachable.

The registered manager kept a log of all accidents, incidents and safeguarding concerns and audited these for patterns and themes.

Staff had an understanding of how to recognise and report any concerns or allegations of abuse and described what action they would take.

Risks to people had been managed safely. Records demonstrated when risk had been identified, action had been taken to reduce them wherever possible.

We found policies and procedures were in place to manage people's medicines safely. Medicines were administered by trained staff who had their competency to do so checked regularly.

The registered manager and staff understood their role in relation to the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) should be put into practice. These safeguards protect the rights of people by ensuring, if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect them from harm.

There were sufficient staff on duty with the necessary skills and experience to support the people using the service. Training was up to date with staff completing some training electronically. Staff received regular supervision and had an annual appraisal.

Relatives and people felt staff were caring. Staff treated people with respect and dignity and promoted people's independence wherever possible, offering choices and options.

People were provided with a varied and nutritious menu. Staff supported people to eat and drink if required. They ensured people at potential risk of undernutrition received adequate nutrition and hydration.

The provider had information about advocacy services available for people and their relatives.

Care plans were personalised enabling people to receive care and support that was responsive to their individual needs. People were provided with access to health care appropriate to their needs.

The registered provider had a process in place to obtain the views of people and their families by using a survey. The registered manager also held regular meetings for people and their families to attend to express their views, raise issues or concerns as well as providing information.

The registered provider had a system in place to monitor the quality and effectiveness of the service provided to people and their families in order to drive improvement.

The registered manager submitted statutory notifications to CQC when necessary. People's personal information was kept safely and securely in line with Data Protection Act.

The registered provider had a business continuity plan in place to ensure staff had guidance and contact numbers in case of an emergency. People had an up to date personal emergency evacuation plan (PEEPs) on their file. A copy was also held in a grab bag which contains equipment and information for staff to access in case of an emergency.

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.

The provider had a thorough recruitment process and carried out all necessary checks before employing staff.

There were enough staff to meet people's needs.

Risks to people's safety were assessed regularly and managed safely.

Is the service effective?

Good

The service was effective.

Staff understood how to apply Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily.

Staff were appropriately trained to meet the needs of the people using the service.

The service monitored and assessed people's health needs. People had access to other health care professionals where necessary.

Is the service caring?

Good

The service was caring.

Staff were caring and compassionate and demonstrated respect and dignity to the people they supported.

Staff promoted people's independence wherever possible.

The provider had information about advocacy services available for people and their relatives.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and reflected people assessed

needs. These were reviewed regularly.

The provider had a policy and procedure in place to manage complaints. Relatives and people knew how to make a complaint.

People were provided with activities and leisure opportunities.

Is the service well-led?

Good

The service was well-led.

People living at the service, staff and relatives found the registered manager approachable.

Quality assurance systems were in place for monitor the quality of the service.

The registered manager ensured statutory notifications were completed and sent to CQC in accordance with legal requirements.

Daisy Nook House

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 24 October and was unannounced. This meant the provider did not know we were coming.

The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed other information we held about the service and the provider. This included previous inspection reports and statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We also contacted the local Healthwatch, the local authority commissioners for the service, the local authority safeguarding team and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with eight people who lived at Daisy Nook House. We spoke with the registered manager, the deputy manager, one senior care worker, two care staff, and the activities coordinator who were all on duty during the inspection. We also spoke with seven relatives of people who used the service, who were visiting at the time.

We spent time observing care delivery at various times throughout the day, including the lunchtime experience in the dining room. We carried out some observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of four people, the recruitment records of two staff, training

records, and medicine records for four people. We also viewed records in relation to the management of the service.

Good

Is the service safe?

Our findings

Relatives we spoke to felt their family members were safe. One relative told us, "I cannot fault the home, I know the [registered manager] well, and the staff are fantastic I have no qualms about [family members] safety." Another relative said, "It's very good, we have no problems, in fact they go above and beyond." A third told us, "It's a lot better now, it's cleaner, more pleasant." People also told us they felt safe. One person said, "I am very safe, I spend time with [registered manager] we get on." Another told us, "I'd rather be here than at home."

One person told us, "No-one comes in or out without staff knowing about them." We were asked to sign in the visitor's book on arrival and again when we left the service.

We checked to make sure medicines were being managed safely. The provider had policies and procedures available for staff guidance. Medicines were stored in a locked trolley and several wall and base cupboards in the locked medicines room. The trolley contained three plastic boxes containing boxes of medicines for the people who lived on the three different units in the service. We found some of these boxes were not secured properly and many had strips of medicines sticking out the top of the box. We found not all bottles and boxes of medicines had 'opened date' stickers in place. We discussed the safe storage of some medicines with the registered manager and they agreed to take action to address the issue by utilising another medicine trolley as storage and to remind staff to place stickers on boxes and bottles when they opened new stock.

We made a recommendation that the registered provider ensure storage of medicines should be in line with current legislation and guidance, and that the storage of medicines is monitored. The registered manager confirmed the day after the inspection that they had stored peoples boxed medicines separately in another medicine trolley.

A fridge was available to store medicines that required cool storage. Records confirmed that temperatures were checked and recorded daily. Each person had an individual Medicine Administration Record (MAR) which gave clear instructions on what medicine people were prescribed, the dosage and timings. The MAR's were completed correctly with no gaps or inaccuracies. We found a MAR for one person whose medicines were administered covertly, this was being managed appropriately under MCA and best interest?
The MAR contained details of the medicine, strength and timing but did not contain actions for staff to follow in terms of preparing medicines. The registered manager contacted the pharmacy who printed a new MAR containing details as to whether the medicine could be crushed or emptied, if a capsule.

We found staff had received the appropriate training for administering medicines. The provider had implemented a new recording system to demonstrate staff training and competency check dates. We saw one record had already been put in the MAR file. The record had the staff member's photograph, date of training, including refreshers and dates of competency checks.
We observed people receiving their medicines. People were approached sensitively and the medicine was administered safely. The care worker spoke gently with people, providing reassurance and encouragement.

We observed the care worker knock on a person's door to ask if they needed anything for pain relief. MAR's were completed after each medicine was given. This meant accurate records were made as people accepted or refused their medicine.

Regular audit checks of MAR's were carried out, one senior carer worker told us, "We do five medicine audits a day." Records supported this. This meant there was a system in place to promptly identify medicine errors. One of the senior care workers had overall responsibility for the management of medicines from ordering to returning medicines.

We looked at staff recruitment records. These showed checks had been made with the disclosure and barring service, (DBS) these were carried out before they were employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people. Records contained completed application forms and references had been obtained.
The registered manager used a dependency tool to ensure staffing levels were appropriate to peoples assessed needs. We reviewed the current week's rota and recent weekly rotas. The service had enough staff on duty, depending on people's assessed support needs and activities for the day. Support plans set out the level of care each person needed. Staff were visible in the service and call buzzers were answered promptly during our time at the service. Even though most people we spoke to felt there was no problem with staffing, some told us they waited for five to 10 minutes before a staff member answered their bell. One person told us, "Some days are good, some better than others." Another told us, "You press the bell, and staff come." A third told us, "If we want help, we get it, they say we will be back in a minute and they do." One staff member told us, "It is not always possible to always have everyone on duty as planned, if we do have a shortage, we deal with it at handover as a team, the registered manager is always available when we need her."

Staff told us, and training records showed staff had completed up to date safeguarding training. Staff knew how to keep people safe and gave examples of following support plans and risk assessments. Staff were able to describe signs of potential abuse. For example, if a person was being abused they may be upset or their eating habits may change. All the staff we spoke with knew what to do if they suspected or witnessed any abuse. One staff member told us, "I would tell [registered manager] they would definitely respond to anything like that." The provider had an electronic system for the recording and the monitoring of safeguarding concerns. Investigations were carried out and lessons learnt used to improve practice through team meetings and supervisions. For example, staff had received supervision to remind them about the timeliness of putting equipment away after its use.
Risk assessments were completed for people using the service based upon their needs. For example, falls, moving and handling and nutrition assessments which were reviewed regularly. The registered manager told us, "Risk assessments have been updated and we now are working with families to keep them informed of changes." We sawrisk assessments being completed for people who were at risk of choking, these included referrals to speech and language therapy along with further assessments and plans to mitigate the risk.

Risk assessments were in place to cover work practices within the service, along with building maintenance records. The staff carried out routine health and safety checks, including hot water temperature checks and fire safety checks. We found the electrical installation check detailed some essential works were required, this had been addressed within a number of days of the original check. Portable appliance testing had been carried out and was due to be refreshed at the end of October 2016?. The service also received medical device alerts, (MDA's) these alerts are sent out by the Department of Health. MDA's are the prime means of communicating safety information to health and social care organisations and the wider healthcare environment on medical devices.

We reviewed the electronic recording system the provider used to record accidents and incidents. We saw the information was detailed and included what happened, the injury and action taken following the incident. The registered manager investigated all accidents and incidents and where necessary provided an action plan to address any concerns. The system looked at patterns and themes. The registered manager told us, "The system allows senior managers to monitor accidents as well, the level of risk is passed on to the most appropriate senior manager so any issue cannot be left open."

We noted checks were in place to ensure the safety and security of the home. We found all records were completed and up to date. For example, regular assessments for fire alarms, water temperatures and gas safety had taken place.
The provider had suitable plans to keep people safe in an emergency. The business continuity plan (BCP) gave instructions for staff in the event of an emergency, such as staffing shortages and utility failure. We saw each person had a personal emergency evacuation plan (PEEPs) on their file. The registered manager advised these were updated whenever there was a change in need. A copy was also held in a grab bag which contained equipment and information for staff to grab in case of an emergency.

We observed staff using personal protective equipment (PPE) correctly and at appropriate times. PPE was available throughout the home. Kitchen staff wore hair nets and ancillary staff were highly visible and followed a cleaning schedule to maintain a high level of cleanliness throughout the home.

Good

Is the service effective?

Our findings

Relatives and people we spoke to felt the service was effective. We asked relatives if they felt staff had the skills and knowledge to provide support for their family member. One relative said, "Yes, without a doubt, the staff are fantastic." Another told us, "I have been quite impressed with staff supporting my [family member], she has not been too well at the moment, she was seen by the doctor and had tests done, staff kept me up to date all the way through." A third told us, "They know the residents well and they know what [family member] likes." One staff member told us, "It is so important to know what people like and the things they don't like, everyone is different."

Staff we spoke to felt confident and suitably trained to support people effectively, training was refreshed when necessary. Staff completed an induction into the service along with mandatory training which covered moving and assisting, health and safety and fire training. The service used a computerised system to record training, the system flagged when training was due to be refreshed or had expired. The system allowed the registered manager to book any face to face training ahead of time to maintain staff's knowledge. One care worker said, "Training is really good, interesting, on induction I was shown round and shown what to do on a day to day basis." The activities coordinator told us, "Since I started work as an activities coordinator I feel I contribute positively in residents' care through all the training I get such as lifting and handling, CPR (cardio pulmonary resuscitation) and many others."

Records confirmed staff received regular supervisions and appraisals. The service had a supervision and appraisal planner. Staff told us they felt their supervisions were important and were used to discuss development and to raise any issues or concerns. One staff member told us, "We have them every few weeks, you can discuss if you're struggling and need help. They [supervisor] can organise training." We found staff had received supervisions to cover lessons learnt from accidents and incidents.

Staff felt communication was good between management, senior staff and care staff, and that people's needs were discussed and updates or actions which needed to be addressed were shared. The staff also maintained daily notes about each person to ensure other staff knew what had occurred prior to them coming on duty. Effective communication meant all staff could carry out their role responsibly.

The Mental Capacity Act 2005 (MCA) providers a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager tracked the DoLS applications and kept a log of each person who had a DoLS

authorisation in place. The file contained the date of the application, the assessment date, the actual date the DoLs was authorised and a reminder of review dates. We found records to demonstrate the registered manager contacted the Council regarding applications.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found for people who had a DoLs in place a copy of the authorisation was on file along with MCA assessments. However people's care plans did not always contain details of the authorisation. We discussed this with the registered manager who advised they would address this.

We spoke to staff about people's DoLS, and asked for their understanding about individual circumstances. Staff were able to describe the reason for the authorisation and how they supported people. For example, accompanying someone to access the community. One senior care worker told us, "DoLS is about making sure you don't deprive them, and MCA is all about their best interests." They showed us one person's records who had a covert treatment protocol in place, this was in date, had been regularly reviewed and referenced within the persons care plan.

Cooperation between care staff and healthcare professionals was evident in care records including social workers, dieticians, pharmacists, community psychiatric nurses and GPs to ensure people received effective care.

People were supported to maintain a varied and healthy diet. Nutritional assessments were completed regularly, along with care records to monitor people's food and fluid intake and weight.
We reviewed food and fluid intake charts and found these were completed in detail. Staff entered the amount of food eaten, for example ½ plate or one or two bites. Fluid input was recorded and totalled; if the total was not met actions were set for staff to follow. The charts also set out if the GP had been made aware of the failure to meet targets.

We observed the lunchtime meal; the atmosphere in the dining area was calm and relaxed. menu choices. The tables were laid with tablecloths, cutlery, napkins and condiments. The staff wore aprons to serve meals. People had cloth napkins to maintain dignity or were asked if they wanted to wear protection for their clothes. Adaptive cutlery and drinking vessels were offered where needed. People were not rushed. The main course choices were well presented and looked and smelt appetising. Although the choice of meal had been made earlier we saw that if someone had changed their minds then the alternative was served. We shared a dining table with three people who were thoroughly enjoying their meal whilst staff members were assisting those who needed prompting or support with eating. The cook and kitchen staff served the meal from a hot locker so food was kept warm. Staff communicated with people during the meal. One person said, "The food is lovely, I like my cereal on a morning and a cup of tea". A staff member stopped and asked, "Do you want a top up?"

We observed tea trolleys in the morning and afternoon, with hot and cold drinks, snacks of cake and biscuits. The service had a snack station in the reception area for people to help themselves to drinks and snacks. Risks to people with specific dietary needs were managed by staff and only suitable snacks were made available to them. In each lounge there were jugs of water and juice available for people, we observed staff offering fluids during the inspection. The cook and staff were aware of people's special diets and were able to describe how thickened fluids were prepared and specific textures of food were prepared. For example, pureed or fork mashable.

The registered manager advised the home was in line for some refurbishment. Plans were in place to build

on the already themed corridors and places in the home to assist in memory recall for people. Memory boxes were being put up next to people's rooms which contained old photographs and items that were important to people. Several touchable pictures decorated the walls, along with boards containing locks and chains for people to touch, fuddle muffs were also available. Fuddle muffs are either knitted or material muffs with small objects sewn in, such as buttons. These can be used by people living with a dementia to reduce anxieties and help with agitation.

Good

Is the service caring?

Our findings

The staff displayed a caring, kind and compassionate attitude towards people and visitors. We observed many positive interactions throughout the inspection and staff clearly knew people well. One relative told us, "They pop in to see [family member]. They are lovely." Another told us, "They go above and beyond, one stayed with [family member] until 2am because they were not well." A third told us, "I was in a review meeting it was good to know how [family member] was like at night. "One person told us, "They look after me so well, helping when I need it, really happy here." Another told us, "Staff seem to be doing their job alright."

We asked staff to tell us how they felt they were caring in their role and how they encouraged independence. One care worker told us, "I look after them all as I would my Dad, t takes team work, being observant, knowing what is in their care plans and learning as you go." Another told us, "We have one to one time with people, they tell us what they want, we listen." A third told us, "We let residents do as much as they can for themselves with support to wipe their face or feed themselves, we also encourage them to join in the meetings and activities."

People told us they were supported to be independent. One person told us, "You can go to bed at any time, it's my choice to have a bath or shower." Another told us, "I do for myself if I can, that's important to me."

Staff were open and relaxed talking openly and listening to people in a caring manner. We saw staff stopping to have a word with people as they passed. Communication between staff and people took many forms such as touch, gestures and facial expressions. We found one person who had communication needs had a communication book, the book contained pictures and support guidelines for staff to use. There was lots of laughter in the home, staff were having a joke with people in an appropriate manner, and at times with family members. Visitors were greeted by the registered manager who clearly knew them well.

People were given choices appropriate to their needs, staff acknowledged people's privacy and demonstrated respect for people by knocking on bedroom doors before entering. Staff used people's preferred names and actively encouraged decision making. Asking questions such as, 'do you want to come along to the lounge or are you happy siting hereOne person told us, "They are lovely and always take time to listen, if you need to know anything you just have to ask, if they don't know they will find out for you." Relatives also spoke positively about the passing on of information. One relative told us, "Never a bother we get to know all that's going on, they are brilliant like that."

Staff used moving and assisting equipment in a dignified manner supporting people but also encouraging independence by supporting them to mobilise independently at a pace appropriate to their needs. People were supported with eating and drinking using prompts at a pace appropriate to them. We observed one member of staff supporting a person to eat their lunch, taking time to make sure the person's mouth was empty before telling them there was another spoonful ready if they were. Personal care was attended to discreetly and clothing changed to maintain dignity. Staff clearly understood people's preferences and were knowledgeable about the care they required. Staff explained to people what they were going to do before

they acted and gained consent either verbally or by gestures.

Staff spent time with people in the communal areas, engaging in conversations, reading with people and having a laugh and a joke. When people gestured towards staff, staff crouched down to eye level and held people's hands gently when speaking with them.

People's dignity was valued, staff supported people with choice of clothes, and made sure they had their hair done and glasses on. One care worker told us, "I always ask what they want to wear on a morning." One person told us, "I have my own kettle and fridge in my room, staff respect my preference to have my laundry done separately, they made it possible for me to have Sky in my room."

The service had information available to people and visitors regarding advocacy. This was on display in the reception area of the service. No one in the service was in receipt of advocacy support.

The provider had a 'One of a Kind Award.' The award was given to recognise and acknowledge individual staff members who exhibited acts of kindness or went above and beyond their call of duty. Relatives, people and other staff members completed a form setting out their comments. We found positive comments were made about individual staff members. For example, 'nothing is too much trouble, [staff member] goes out of her way to see to our needs as well as the patients, I have seen her leave a little later than she should, the best carer.' Another form read, 'carers, cleaners, cooks and laundry go out of their way to support us they work extremely hard.' We found that one of the people who resided in Daisy Nook had also won the 'One of a Kind Award' as they were always helpful and taking upon themselves to do some chores around the home. The registered manager told us, "She considers herself to be part of the staff." On the wall in the reception was a picture of the person and the registered manger taken during the award ceremony.

The communal areas were homely, with pictures and ornaments on display. Lounge areas had a range of seating, with small tables for people to have personal effects close by. Bedrooms were personalised with photographs, pictures and ornaments brought from home. Staff were respectful of people's belongings and ensured people had their important items with them during the day.

Good

Is the service responsive?

Our findings

Relatives and people we spoke with felt the service was responsive. One relative told us, "If they get the Doctor they keep me informed." Another told us, "When my Dad was ill they arranged for my Mum to visit at home, that way she was reassured about Dad's wellbeing, I thought that was great they did not have to do that, but they did." One person told us, "If I am not well then the Doctor comes to see me. I have the nurse sometimes."

We looked at people's care records. Care plans were personalised and reflected people's needs. Care plans and risk assessments had been recently reviewed, we found that relatives were invited to participate in the review. One relative told us, "We can always ask them to get the doctor if we think [family member] is not well, they also get him out. We're kept up to date all the time. [Care worker] knows her inside out."

Not all people could tell us if they had been involved in care planning, but those who couldwere actively involved along with their relatives and were delighted at the overall progress. We found most of the care plans had been discussed with people and relatives and had been signed. There was a plan in place for letters to be sent out to relatives giving them the opportunity to take part in documenting people's needs and preferences by 30 September 2016, the review at 19 September 2016 showed 39 out of 40 letters had been sent. At the time of our visit the updated plan showed 36 out of 40 reviews were completed. The registered manager hoped to have all care plans signed by the end of October 2016?.

We asked staff to explain what they understood by person centred care. One care worker told us, "Everyone is different, they can have a cuppa with sugar one day and none the other, or prefer it in a china cup! It's like providing them with support in a way that matters to them." Another staff member told us, "We read care plans, people decide when they want to go to bed and get up, if they look tired I would ask if they wanted to go to bed."

Staff were able to tell us how they responded to changing and differing needs. One care worker told us, "It starts from the pre-admission assessment, completing the 'my story' in consultation with residents relatives, from there you always continue to ask residents how they feel. Handover is also very helpful in anticipating the level of support required in a given day." They showed us the handover sheet which was very detailed and informative, the sheet contained all the residents names, rooms numbers and staffing needs requirement, mobility and risk factors, medicine issues, hospital appointments, any expected visitors and their purpose along with whether a carer review was due. One care worker told us, "Any changes are recorded and from there assessments are redone and care plans updated."

We observed the registered manager speaking with relatives to keep them up to date with their family member's health and wellbeing. During the inspection a family came to confirm they wanted their family member to live at Daisy Nook House. The registered manager gave clear information about the service and responded to their questions. The registered manager told us, "The family had been to look around before, they have decided to come here."

The registered manager told us about the residents committee in Daisy Nook House which met on a Wednesday evening. The registered manager runs the Wednesday night club, this weekly event was shared by people who use the service, relatives and staff. Relatives viewed it as an opportunity to take part in shared bingo or sing songs with their loved ones. People who used the service saw it as an opportunity to gain updates on current issues affecting the running of the home such as staffing, menus and activities. There was a committee that facilitated the activities of the Wednesday night club which included three people who use services.

We spent time with the activities coordinator to find out about how people's interests were acknowledged and what activities and leisure opportunities took place in the service. They told us, "Mostly we go with what residents like on the day. It's like being guided by 'my life story' which individual residents have completed before or on admission, what they like and what they don't like." Although there was no long term plan in place for activities we found a weekly activity poster had been developed and was on display in various places in the home. The planner showed activities such as, card making for birthdays, travelling zoo, social outings to the local garden centre and local community themed events. The service worked with a local school project where students were encouraged to visit the home to interact with people in conversation or games.

The activity coordinator told us about the 'Wish Tree', this was a concept by which people were encouraged to express their wishes by writing on a 'leaf' this was then tagged to a man-made colourful tree with many branches. The tree was situated in the reception area so everyone could see it and take part. We found varying wishes and aspirations by some people from a wish to visit the theatre or pantomime, or to have a meal out with family members. The activity coordinator told us she regularly checked them, added comments and then planned the wishes of individual people. We saw photographs of people's wishes coming true, for example, having a meal out with their spouse.

The service had a complaint's policy and procedure that was accessible to relatives, people and staff. There had not been any formal complaints made to the service. The registered manager told us that any minor comments or concerns could be dealt with immediately so these did not develop into complaints. All the people we spoke with felt confident to speak up, and that there were opportunities to have things sorted out before they get worse. One person told us, "I would certainly speak with the registered manager if I had a problem." Another said, "If I had to complain it would be sorted." One relative told us, "My [family member] is very outspoken, she always tells it as it is, therefore won't have a problem about raising a concern with anyone, that's why she is on the residents committee.

Good

Is the service well-led?

Our findings

Relatives and people we spoke to felt the home was well-led and management in the home was good. A relative told us, "[Registered manager] is very approachable. She always has a bubbly personality." Another told us, "The home has continued to improve since [registered manager] has been a manager, she keeps on top of things." One person told us, "You never hear her shouting like in the old school, she is very good and lots of fun." Another told us, "When I was admitted to hospital, [registered manager] came to see me, she is on the ball." A third person told us, "[Registered manager] is very receptive, she follows things up."

Staff told us they were happy in their work and felt supported by the management in the home. One staff member told us, "[Registered manager] is caring and bubbly, she helps in any way, you can speak to her and she will get any problems sorted." Another told us, "I can speak to our deputy or the manager about anything, if not then I can contact the company's hotline. [Registered manager] our home manager runs an open door session every Wednesday, we also have regular staff meetings and supervisions."

The service had a registered manager in place. The CQC registration was on display along with a copy of the most recent inspection report. We saw that the registered provider ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements. The registered manager kept a file of all notifications sent to CQC. The home kept all personal records secure and in accordance with the Data Protection Act.

We examined policies and procedures relating to the running of the home. These were reviewed and maintained to ensure staff and people had access to up to date information and guidance. Staff were aware of policies and read these as part of their induction process.

We found evidence of accidents, incidents and allegations of abuse being reported. The registered manager audited these to identify if there were any trends or patterns. For example, we found referrals to the falls team and discussions in staff supervision records following an incident where equipment was not stored correctly.

The service had a development plan in place which was reviewed and monitored by the registered manager and the regional manager. The service had over the past months introduced new documentation; this was being embedded in the home. The registered manager told us, "I did the care planning training twice, I needed to make sure I fully understood." We reviewed the plan and found all the actions to date were completed, where actions were not fully complete we found these had a target date for end of October or November 2016. This meant the registered manager was working in line with the plan to continue to develop the service.

The quality assurance process covered areas such as care plan audits, medicine audits and health and safety audits. The registered manager also completed out of hours and weekend visits, as well as daily walk arounds. Findings were recorded and any concerns or issues actioned. We found where actions were recorded these had been completed and signed off.

Records showed the registered manager held regular meetings with staff, people and relatives. Meeting minutes were available. The service carried out surveys on an annual basis to capture views of relatives and people who used the service. The recent feedback survey was in June 2016. This indicated 100% satisfaction on the home being well maintained, safe and secure, providing choice, access to visitors, GPs and other health and social care professionals. There were also positive responses for complaints handling, atmosphere in the home and the homes decor. One relative told us, "I did the survey recently." Comments included, 'Daisy Nook is a lovely home, staff and other residents are very nice,' 'Nana thinks of this home as her home, our family are very reassured,' and 'thanks to staff for all their hard work and best care.'

The registered manager told us, " We are very much part of the community here, there are a lot of older people who live very near the service and they have our telephone number, if they are unwell they can ring us and we can get them some help." We found the local church visited the home on a weekly basis, as well as people attending church services.

The registered manager told us they felt supported by the regional manager who visited the service regularly to review the development plan. They told us, "The office sends me all the resources I need, all I have to do is ask, they do listen. I like to be in control of any change, I am the person who looks after Daisy Nook and I have the responsibility for the residents and staff. If I am unsure about anything I can have weekly conference calls with the clinical lead. It's important for me to get out there and see what's going on." During the inspection the registered manager was highly visible to people, relatives and staff and clearly knew people and their families well.