Downing (Barwell) Limited

Saffron House

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

Summary of findings

Overall summary

This inspection visit took place on 4 April 2017 and was unannounced.

Saffron House provides residential care for older people, some of whom were living with dementia when we visited. It is registered to accommodate up to 48 people. There were 37 people using the service on the day of our inspection visit.

At our last inspection carried out on 23 June 2016 we found that the provider had not met the regulations relating to safeguarding people from abuse, staffing and good governance. They had also failed to notify us of significant events that had occurred at the service. They wrote to us to tell us how they intended to make the required improvements. At this inspection we found that the provider had made the required improvements.

The service had a registered manager. 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.

People were safe and their relatives confirmed this. Staff understood their responsibilities to keep people safe from avoidable harm. The provider had followed safe recruitment practices.

Risk associated with activities of people's care had been assessed and measures were in place to prevent avoidable harm. The environment and equipment was checked and maintained in order to keep people safe.
There was a suitable number of staff when we visited. The provider checked that staffing numbers remained sufficient.
People received their medicines as prescribed by their doctor. People were supported to maintain their health and had access to health professionals.

People were supported by staff who had received training and support to meet their needs. Staff felt supported and their competency in their role was checked.

People enjoyed their meals and were supported to have enough to eat and drink. Where people had dietary requirements, these were met and staff understood how to provide these.

People were supported in line with the requirements of the Mental Capacity Act. People's mental capacity to consent to their care had been assessed where there was a reasonable belief that they may not be able to make a specific decision.

Staff at all levels treated people with kindness and compassion. Dignity and respect for people was

promoted. People felt valued and that they were listened to.

People's care needs had been assessed and were reviewed to make sure that they continued to meet their needs.

People's independence was promoted and people were encouraged to make choices. They had access to activities so that they could remain active and follow their interests.

The registered manager had sought feedback from people and their relatives about the service that they received. We saw that they had taken action based on this feedback. The provider's complaints procedure had been followed when a concern had been raised and people felt able to make a complaint if they needed to.

Staff felt supported. They were clear on their role and the expectations of them.

People and their relatives felt the service was well led. Systems were in place to monitor the quality of the service being provided and to drive improvement.

The registered manager was aware of their responsibility to report events that occurred within the service to CQC and external agencies.

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 were safe and their relatives confirmed this. Staff understood their responsibilities to keep people safe from avoidable harm.

People received their medicines as prescribed by their doctor.

Risks associated with people's care and the environment were assessed and managed to prevent avoidable harm to people.

There was a suitable number of staff and the provider followed safe recruitment practices.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received training and support to meet their needs.

People had consented to their care. Where they were unable to consent, this had been assessed and decisions were taken in people's best interest.

People enjoyed their meals and were supported to have enough to eat and drink. People were supported to maintain their health.

Is the service caring?

Good

The service was caring.

Staff at all levels treated people with kindness and compassion.

Dignity and respect for people was promoted. People felt valued and that they were listened to.

People's independence was promoted and people were encouraged to make choices.

Is the service responsive?

Good

The service was responsive.

People's care needs had been assessed and were reviewed to make sure that they continued to meet people's needs.

People had opportunities to remain active and follow their interests.

The registered manager had sought feedback from people using the service. People understood how to make a complaint if they needed to and were confident that it would be addressed.

Is the service well-led?

Good

The service was well led.

People's relatives felt that the service was well led. They told us that the registered manager was approachable.

Staff felt supported by their managers. They were clear about their role and responsibilities and had access to the provider's policies and procedures.

Systems were in place to monitor the quality of the service being provided and to drive improvement.

The registered manager was aware of their legal responsibilities.

Saffron 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected the service on 4 April 2017. The inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, to detail what the service does well and improvements they plan to make. Before our inspection visit we also reviewed information we held about the service. This included previous inspection reports and notifications sent to us by the provider. Notifications tell us about important events which the service is required to tell us by law. We contacted a local authority who had funding responsibility for some of the people who were using the service. We also contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services to see if they had feedback about the service.

As part of our inspection we observed staff and people's interactions and how the staff supported people. Our observations supported us to determine how staff interacted with people who used the service, and how people responded to the interactions.

During our inspection visit we met and spoke with six people who used the service and with five relatives. We spoke with nine members of staff including support staff, a kitchen assistant, the person who oversees the maintenance for the building, a team leader, the deputy manager, the registered manager and the area manager. We looked at the care records of five people who used the service, people's medicine records, staff training records, three staff recruitment files and the provider's quality assurance documentation. Following the inspection visit we spoke with a health professional who had regular contact with the service to gain their feedback.

Good

Is the service safe?

Our findings

During our last inspection we found that the provider had failed to safeguard people from the risk of abuse. These matters were a breach of Regulation 13: Safeguarding service users from abuse and improper treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014. We checked to see if they were now meeting this regulation and found that they were.

Staff were aware of how to report and escalate any safeguarding concerns that they had within the service and, if necessary, with external bodies. They told us that they felt able to report any concerns. One staff member told us, "We report incidents to the manager and if not taken seriously we can go higher. Or we can go outside the organisation." Another staff member told us how they would follow the provider's safeguarding policy. They said, "If they didn't do anything I would be a whistle-blower." Staff were able to recognise the signs and symptoms of abuse. The registered manager was aware of their duty to report and respond to safeguarding concerns. They had ensured that all staff had received training with regards to identifying safeguarding concerns and taking appropriate action if they had concerns. We saw that there was a policy in place that provided people using the service, their relatives and staff with details of how to report concerns and who to.

During our last inspection we found that the provider had failed to ensure that there were enough suitably qualified staff to meet people's needs. These matters were a continued breach of Regulation 18:Staffing. Health and Social Care Act 2008 (regulated activities) Regulations 2014. We checked to see if they were now meeting this regulation and found that they were.

We received mixed feedback about whether there were a suitable number of staff to meet people's needs. Some people told us that there were enough staff to support them. However, one person's relative told us, "I don't think there are enough staff they are over worked." Most staff told us that staffing levels were sufficient to meet people's needs. They told us that numbers had improved at the weekends and staffing levels now reflected the rotas. They had not done at the time of our previous inspection. On the day of this inspection a staff member had cancelled their shift due to sickness. The registered manager was offering support whilst cover was sought. We saw that an agency member of staff later arrived to provide support. Some said they felt too stretched and that this meant they did not have time to give people the level of attention they wanted to. An external professional confirmed that they felt there were a sufficient number of staff available when they visited. The registered manager completed a dependency tool each month to evaluate if staffing levels were suitable to meet people's needs. They told us that in addition to this they completed a daily manager audit and assessed staffing levels. They told us that they believed staffing levels were suitable at the time of our inspection. We noted that during our visit people received support without delay and call bells were not left unanswered for long periods of time. The staffing rota reflected the agreed numbers of staff required. We found that there were sufficient numbers of staff to meet people's needs on the day of our visit.

People and their relatives told us that they felt safe. One person said, "I don't have to worry I feel safe." A person's relative said, "I feel he is safe here." Another person's relative told us, "I have never seen anything of

concern."

People were protected from risks relating to their day to day care. We found that risk assessments had been completed on areas such as moving and handling, nutrition and skin care. The information within these included assessments and guidance from external health professionals where appropriate. For example, a speech and language therapist had advised that a person be provided with meals that were of a softer texture to prevent the risk of them choking. Where staff were required to take action in order to minimise the risk of harm, we saw that they did. For example, people were supported to be repositioned regularly in order to protect their skin. A staff member told us, "We turn people regularly and this is recorded and the interval is advised by the nurse." We saw that when people's needs changed, staff guidance had been updated to reflect this. This meant that staff had the information they needed to minimise the impact of the risk.

Some people displayed behaviour that could have caused harm to themselves and others. Staff knew how to offer safe support should this have occurred. A staff member told us, "If I saw a person was getting anxious with another person, we would intervene. We are aware of triggers, it's in the care plan." Care plans had not always been written with sufficient detail to identify what may cause a person to display this type of behaviour and the ways that staff could support them to avoid these. We brought this to the registered manager's attention. They told us that they would review the guidance that was provided to staff to ensure that this information was included.

Where people needed it there was equipment in place to help keep them safe. A staff member told us, "Make sure everything is in place for a person, the equipment. Staff know what they are doing." Equipment was regularly checked and maintained to ensure it was safe for use. Risks associated with the environment, tasks carried out and equipment used had been assessed to identify hazards and measures had been in place to prevent avoidable harm. Where regular testing was required to prevent risk, such as water safety testing, these were recorded as having happened within the required timescales. Where testing had identified a concern, action had been taken to address it immediately. A system had been implemented so that staff, visitors and people using the service could report any maintenance issues or faults. The registered manager checked that any reported concerns were rectified.

The help that people would need if there was a fire had been formally assessed. People and staff had practiced the actions they should take in case of a fire. Records reflected that fire safety checks were carried out and there were procedures in place for staff to follow. The person who oversaw the maintenance and safety of the building told us that they had implemented additional checks on the fire safety equipment to ensure that they were safe. There was a suitable plan in place to be used in the event of an emergency or an untoward event.

Accidents and incidents were recorded. There were systems in place to ensure that the right action was taken following an incident to prevent a reoccurrence. The registered manager was required to report on all incidents to the provider. This included analysis of accidents or incidents and the actions that they had taken. Where people had fallen, this was audited monthly in order to take into account any factors contributing to falls such as the location or time of day. The registered manager was working with the local authority falls team to assess if the right support and equipment was in place for people who were at risk of falls.

We noted that the home environment was clean and homely. There was an ongoing programme of maintenance and redecoration. On the ground floor we noticed a malodour. We saw domestic staff working throughout the day and every effort was made to keep the home clean and odour free. The registered manager told us that they had removed some items of furniture that had an odour and that each area of the

home was regularly deep cleaned. The registered manager checked that cleaning had occurred to the required standard and timescales. The area manager's checks had identified an odour in the weeks previously and, having spoken with the domestic staff, had ordered new cleaning products in an attempt to tackle the concern. They told us they were working closely with the domestic staff to monitor if any improvement were noted following this change.

People could be assured that they would receive their medicines as prescribed by their doctor. One person said, "They bring my pills when I need them." A person's relative said, "Staff give him his medicines, he gets them when he needs them and they give him them on a spoon." A staff member explained to us, "Seniors have responsibility for ordering and checking medicines, including stock levels and returns. We get to know the person and how they prefer the medicines, for example someone may prefer to take it from a spoon whilst another person may prefer it being given in their hand. This will be in their care plan." We observed that the person administering medicines to people had a patient approach. They understood how people liked to take their medicines and offered them encouragement when needed.

Medicines were stored securely. We saw that medicine administration record charts were used to inform staff which medicine was required and this was then used to check and dispense the medicines. Where people had PRN (as required) medicines there were protocols in place to guide staff. Where people required creams to keep their skin healthy, records were kept that demonstrated that these had been administered. We noted that these lacked guidance for staff to know where the creams should be applied. We discussed this with the registered manager. They informed us that they would ensure that clearer guidance was implemented immediately. We saw that a stock check of medicines was taken regularly. Staff had received appropriate training before they were able to administer medicines to people. They had sought guidance from health professionals when they had become concerned about a person's medicine regime. We asked the registered manager to seek further guidance with regard to how one person should receive their medicines to make sure that they were safe. They told us that they would. Staffs practice with regard to medicines administration was monitored to ensure that it continued to be safe.

The provider had followed their recruitment procedures. These made sure as far as possible that only people suited to work at the service were employed. The necessary pre-employment checks had been carried out. These included Disclosures and Barring Service checks. These are checks that help to keep those people who are known to pose a risk to people using Care Quality Commission (CQC) registered services out of the workforce.

Good

Is the service effective?

Our findings

People were supported by staff who had the skills and received training to meet their needs. One person's relative told us, "The staff know what they are doing." A staff member said, "Things improved over the last few months, training has improved a lot. All my training is now up to date. I get regular supervision." Another staff member told us, "We have put a lot of work in over the last few months, we now have all done our training. All staff have completed eLearning training." Training records showed that staff had received training relevant to their role. These included aspects of health and safety, safeguarding people and understanding dementia. We saw that staff received refresher training in order to ensure that their knowledge remained current. New staff were inducted into the service and given the opportunity to shadow experienced staff in order to learn the practical elements of their role. They were required to complete induction training which followed the Care Certificate standards. The Care Certificate is a national induction tool, the standards of which providers are expected to follow, to help ensure staff work to the expected requirements within the health and social care sector.

Staff were supervised and supported in their role. One staff member told us, "We receive regular supervision, topics cover any concerns we may have, if we want more training. Seniors can also do supervision, so a member of staff may want to talk to us about something, we would record this on the supervision form." We saw that the registered manager had used staff supervisions to check staff's understanding of the provider's policies and other aspects of their role. Staffs competency in their role were regularly assessed and monitored. One staff member told us, "Competencies are checked and senior staff have completed the level 3 eLearning for medicines administration." We saw that some staff had been retrained following a competency assessment around how they supported people with their mobility. This meant that the registered manager made sure that staff knew the requirements of their role.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that people were being supported in line with the MCA. The registered manager had requested DoLS authorisations for people who may require them. We saw that mental capacity assessments had taken place when people needed them. Decisions had been made that were deemed to be in people's best interest when it was evidenced that they no longer had the mental capacity to make the decision for themselves. We saw that the least restrictive option had been considered. It was not always clear that the people who were best placed to make the best interest decision on the person's behalf were involved. For example, their relatives and their doctor. The registered manager told us they would review how best

interest decisions were recorded to ensure that this information was made clear. Where people retained the mental capacity to make some decisions, such as what to wear and what to drink, this was recorded so that staff had guidance.

Staff had a good understanding of the MCA and how it applied to their role. One staff member explained to us how decisions were made in people's best interests where this was required. Another staff member was able to explain what unlawful restrictions would be and the legal framework around DoLS. Training records indicated that staff had received training about the MCA.

Where people had the mental capacity to consent to their care, this had been sought. One person said, "They always ask me if I need help before they do anything." Staff understood that they needed people's consent before supporting them. Some people had signed consent to care forms within their care plan to say that they consented to the care that they received. Other people had not signed consent forms but we saw within care plans that people had been asked and their consent verbally obtained.

People's health care needs were met. One person said, "If I am not well they will they will call a GP." A person's relative confirmed this. They said, "They keep me informed of changes in [person] if he is not feeling well. He sees a GP and he has seen a chiropodist." Staff confirmed that health care professionals were contacted if there was a medical concern and that a doctor visits the home on a weekly basis. One staff member said, "I would tell a senior if someone wasn't well and they would contact the GP. The GP visits on Thursdays. The nurses come in as well." An external health professional told us, "They are quick to refer." People's care records reflected that people had access to health professionals for routine check-ups as well as when their health was of a concern.

We received positive comments about the meals that were provided. One person told us, "There is plenty to eat and lots of drinks, I enjoy the food, it is grand, we have chicken soup with big bits of chicken in, lovely." A person's relative said, "The meals are nice, there is a good variety, they get plenty of drinks and at tea time they have a hot tea or sandwiches, all the cakes are homemade. [Person] enjoys his meals."

We observed the lunch time service. People were asked if they wanted aprons to protect their clothes. Where people refused, this was respected. The tables were set with cutlery and juice. Staff asked people what they would like to eat and for some people they brought both meals so they could choose between the two. The meal appeared to be appetising and was nicely presented. People were supported discreetly. For example, a person was brought their meal and the staff member asked quietly if they needed help to cut it up. The person replied positively and the staff member proceeded to help. They also brought the person a plate guard so they were able to eat independently. We did observe that meals were brought plated so people did not have the opportunity to add their own vegetables or gravy. We suggested to the registered manager that this would aid people's choice. They agreed and told us thay would ensure this practice was adopted. We also saw that the menu board had been completed to inform people of what was available to eat for the day. However, it was difficult to read. The registered manager told us that they had identified this and planned to have an easier to read version implemented in the near future.

Where people had specific dietary needs, these were catered for. For example, where people had been assessed by a health professional as being at risk of choking, soft or pureed meals were provided. A staff member told us, "The kitchen is informed of anyone on a specialist diet. Where people are assessed at risk they are on food and fluid charts." Throughout our inspection visit we saw that drinks were offered and kept within easy reach of people. In these ways people were supported to have enough to eat and drink.

Good

Is the service caring?

Our findings

People told us that staff were caring. One person told us, "Everyone looks after you, you don't go without anything." A person's relative said, "They are very caring staff, the home is clean and Mum is happy here". Another relative told us, "The staff go above and beyond on care." We observed staff interacting with people throughout our visit. Their approach was kind and considerate. Staff at all levels demonstrated a caring approach. We saw that a senior staff member who oversaw the maintenance, domestic and admin staff interacting with people throughout our visit and took time to speak with people. They told us, "It's about knowing and interacting with the residents. I take time to say 'hello'." The person who oversaw the maintenance of the home told us that they had moved the timing of the weekly fire alarm test to ensure that it did not co-incide with when people were having their meals. They had noted that it unsettled people. In these ways staff demonstrated a caring approach.

People were respected and their privacy was maintained. One person told us, "Oh yes, they are very good when they help me, they cover me up and I don't feel embarrassed." We saw that a person was at risk of compromising their dignity due to their behaviours. Staff were guided to support this person in a way that maintained their dignity. A staff member told us, "We cover a person up when giving personal care. We make sure the door is closed and curtains are drawn, always offer reassurance." Another staff member told us how they encouraged a person to attend to their personal care needs in a manner that was respectful and reassuring.

People's independence was maintained and promoted. One person told us, "Staff encourage me to do as much as possible." A staff member said, "Encourage people to do as much for themselves. During personal care if they can wash their face support them to do that. If they are able to choose their own clothes support them to do that." We observed that staff were patient with people and encouraged them to do things for themselves. For example, one person was assisted to stand. This took in excess of 15 minutes and staff were patient. Eventually a stand aid was used to help the person. This approach had been recorded as the person's preferred way to be supported to stand as documented in their care plan.

People were able to receive visitors without undue restriction. One relative told us, "I can visit anytime, there are no restrictions, I am offered meals if I want to eat here." Another person's relative told us, "I visit when I feel like it and I am made to feel welcome. I have been asked to stay for lunch and tea" We saw from the visitor's book that people had visited throughout the day.

People told us that they felt valued and were listened to. One person said, "Staff always listen to me, they are very good. I don't feel ignored." A staff member told us, "We ask how people want to receive their care and we speak with families. Some like care in a particular way, for example one person doesn't like a bath, they have a strip wash, this is in their care plan." The registered manager told us that they encouraged staff to spend time sitting with people and talking with them. During our visit we saw that staff did this. Some staff, including the registered manager, ate their lunch with people. This gave people a chance to talk with staff in a social setting. People's relatives told us that they valued this.

People were supported to make choices and be in control of their lives. A person's relative told us, "Staff ask him what time he wants to go to bed and get up." One staff member said, "We ask people what time they want to go to bed and get up. If they are awake in the night we ask them if they want a cup of tea and some toast. If they want to get up we would support them to do this." We saw within peoples care plans that staff were guided to offer people choices and how best they might do this.

Some people's bedroom doors had been personalised with a photograph to help them orientate themselves. There was signage around the home so that people were able to find the facilities that they needed. The registered manager told us that they intended to improve the use of signage within the home to aid people's orientation further. We saw that calendars were used in the home to help orientate people to the day. We saw that the calendars were set to the wrong days. One was set to 28 March. This was likely to cause confusion to people. We raised this with the registered manager who immediately ensured that the calendars were set to the correct date.

Where people were at the end of their lives, they received care in a way that they wanted to. A staff member told us, "We have received training in end of life care. It's about respect and dignity; they are pain free and comfortable. We support the family and if they want to stay overnight they can." People's advanced wishes had been sought.

Good

Is the service responsive?

Our findings

People's needs had been assessed. They had care plans in place for staff to follow to ensure that people's needs were met. A staff member told us, "We assess people prior to coming to the home so we know what they need and have the skills to support them." Care plans contained information about people's preferences and usual routines. This included some information about what was important to them, details of their life history and information about their hobbies and interests. Staff were guided to provide support to people in the way that they wanted in order to meet their care needs. The registered manager was in the process of implementing a document called 'Know me better.' This was with the aim of streamlining the information that was kept about people to make it easier for staff to get the information that they needed and to involve people more in their care planning.

People were able to choose if they wished to receive support from staff of the same gender. The deputy manager told us, "People are able to choose a male or female carer, we have had people in the past who have requested female only care staff and we have been able to do this. This is asked at assessment and is reflected in the care plan." Some people had been involved in the planning of their care and, where appropriate, their relatives had been asked to provide information that would support care planning.

We saw that care plans were reviewed to ensure they continued up to date information with regard to people's care needs. Care plans were updated if people had any changes in their needs; where there were no changes this was noted in the records. People and their relatives were involved in some of the care plan reviews. For example, a relative was concerned that their family member was not offered fruit as a snack. The registered manager arranged for fruit to be routinely offered to this person as well as other people using the service. On another occasion we saw that the registered manager had discussed a person's wishes with them when they came to the end of their life. Their wishes had been recorded in the care plan for staff to follow. The registered manager told us that further involvement of people in their own care planning had been identified as a service improvement goal and that they were working towards this.

The provider had an equality and diversity policy and staff had received training to ensure that they were able to meet the requirements of the policy. A staff member told us, "We mustn't judge anyone and treat people as we would want to be treated." The service's statement of purpose set out that people had 'The right to receive an anti-discriminatory service which is responsive to your race, religion, culture, language, gender, sexuality, disability and age.' People were supported to practice their religion as they choose and staff were offered information and guidance with regard to people's religious practices. We saw that some people's care plans made reference to their sexuality and any support needs that they may have had around expressing their sexuality. We saw that other care plans did not make specific references to this. The registered manager told us that they would be mindful of this when reviewing people's care plans with them and would make sure that any support needs were identified and implemented.

People had the opportunity to remain active and activities were available for people to take part in. One person said, "I listen to my music, I am in here usually with my door open so I can see what's going on. I am quite happy I am not really interested in the activities. They are a bit childish." A person's relative said, "He

takes part in activities. I have been here when they are playing bingo, He saw a film today." The service employed an activities co-ordinator who had devised a time table of activities for people to take part in. A staff member told us, "They have an exercise class and there are a variety of activities." During our inspection we observed people being encouraged to take part in a bingo game. We saw that some people seemed to enjoy this activity while others seemed to be disinterested and did not fully engage in the game. The service has developed a cinema room where old films were shown and people were offered popcorn and ice cream. We saw that these events were well attended and people gave positive feedback about this facility. We were told by the registered manager that they were working with the activities co-ordinator to expand the variety of activities available to increase opportunities for people that were tailored to people's specific interests.

People's relatives were included in people's care if they wanted them to be. One person's relative told us, "They let me know exactly what's happening. I am getting to know the staff on first name terms, it feels more like a family. Staff call into the room to check mum is ok." Another person's relative said, "I feel involved in decisions and staff listen if I have concerns." We saw records that showed that people's relatives had been contacted to inform them of a change in a person's wellbeing.

People told us that they would feel comfortable making a complaint. One person's relative told us, "I would speak to the manager. I am very confident it would be dealt with." Another person's relative said, "I have not needed to complain but would speak to [staff member]." We saw that the provider's complaints procedure was on display within the home. However this was not easily accessible for people. As it was clearly displayed in communal areas. Following our inspection the registered manager had made sure that the complaints procedure was prominently displayed throughout the home. We saw that where complaints had been received, they had been investigated and action taken to address the concerns were taken. Where necessary the provider had issued an apology. A staff member told us, "If things go wrong we look at what happened and support each other to get it right next time."

People had been asked for feedback about the service that they received. People using the service and their relatives were invited to meetings where they were encouraged to offer feedback. During these meetings people's views were sought about the service. For example, people had been asked their opinions about the decor as part of the ongoing redecoration programme. We saw that a piano had been purchased for a communal room at a person's request. Following our visit the registered manager informed us that the weekly menus had been updated to reflect the feedback that people had given at the residents meeting. The provider had conducted satisfaction surveys with people using the service and their relatives. At the time of our inspection the surveys had been sent out but the results had not yet been gathered and collated. The registered manager told us they would take action based on the results and communicate the result with people using the service and their relatives.

Good

Is the service well-led?

Our findings

At our last inspection we found that the provider had failed to notify us of significant events. These matters constituted a continued breach of Regulation 18 of the Care Quality Commissions (Registration) Regulations 2009. Providers are required to ensure that CQC is informed of significant events that happen in the home. At this inspection we found that the provider had notified us appropriately. The registered manager was aware of their responsibility to notify us of events. We saw that they had informed us about incidents that had happened. From the information provided we were able to see that appropriate actions had been taken.

At our last inspection we found that robust monitoring of the service and care delivery within the home was not taking place. These matters were a continued breach of Regulation 17: Good governance of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. At this inspection we found action that there were robust systems in place to monitor the service to ensure that good quality care was delivered to people.

There were systems in place to review service delivery to ensure that it met people's needs. One staff member told us, "We know what a high quality service is; we observe practice on a regular basis to make sure staff are following best practice. We check that all charts are not only completed but reflect the care given. Staff are dedicated to improving care. We ensure that families are happy as well." We saw that there were a range of audit systems in place to measure the quality and care delivered so that improvements could be made. These included medicines management, accidents and incidents and health and safety practice. These were effective in highlighting ways to improve the service. The registered manager conducted daily walk arounds and audits to check that people were receiving the care that they should be. We saw that they had taken action when audits had identified areas for improvement.

The provider had a detailed quality monitoring system in place. We saw that the registered manager was required to provide information, such as accidents and incident and staff training and details of staff supervision to the provider so that they could monitor the service. The area manager visited the home at least twice a week in order to support the registered manager and review systems to make sure improvements were sustained. During these visits they completed a full audit of all aspects of service delivery. This included speaking with people who used the service. Any areas for improvement that were identified through the visit were put on an action plan for the registered manager to follow. This was to ensure any actions required were addressed. The registered manager was required to feedback their progress against the outstanding actions. The provider had demonstrated that they were committed to measuring and reviewing the delivery of care and that effective quality assurance processes were in place.

There was a drive to make improvements and to develop the service. Where concerns had been identified through the registered manager's or provider's own audits or from an external source, we saw that action was taken to address the concerns. For example, we saw that the registered manager had used staff supervision to check that all staff understood the procedure that they should follow if they discovered a person had stopped breathing. We saw that they had checked all staffs knowledge not just care staff. They told us, "You never know which staff member might find someone." The registered manager had responded

to feedback from external professionals and was making changes as a result. An external health professional told us, "[Registered manager] seems to be taking on board the things we are suggesting." We saw that the registered manager used our previous report to guide them in making improvements to the service.

People's relatives told us that they felt that the home was well led. One relative said, "The home is very good and they look after mum. If they didn't, mum wouldn't be here." Another relative told us, "They have helped me so much, with social services. It was all new to me and [registered manager] has really helped, even the receptionist has helped. They leave nothing to chance." They went on to say, "I have a lot of confidence in this care home." A third relative said, "Staff are good at sharing information they are open and helpful." Staff told us that they had faith in the newly appointed registered manager. One staff member said, "[Registered manager] she is doing well." An external health professional told us, "They have a clear lead on who is doing what. The team know who to go to."

Staff felt supported and motivated in their roles. One staff member told us, "Training and support is good now. We support each other; we work as a team to get through it." They went on to say, "[Area manager] is also supportive, he is available, we receive feedback on our performance and we have regular management meetings." We saw that the registered manager had allocated staff members lead roles based on their skills, experience and interest. This was with the aim of empowering staff and encouraging them to take ownership of a particular area of the service in order to improve it. For example, staff members had been appointed as 'nutrition champions' and other staff had taken on the role of 'infection control champion' for the home.

Staff were clear about their roles and responsibilities. They had access to the provider's policies and procedures and understood how to follow them. The registered manager had introduced a policy of the month which all staff were required to read and sign to say that they were able to follow the guidance. We saw that where staff practice or knowledge was identified as a concern, action was taken in line with the provider's disciplinary policy. Actions taken following concerns raised had included terminating staff's employment or retraining and offering additional support.

The provider had a duty of candour policy. Duty of candour is a requirement of providers to act in a way that is transparent and open with people and other agencies. We saw that the provider's policy was followed when incidents had occurred in the home. It was not always clear from some incident reports if the duty of candour process had been followed. We discussed this with the registered manager who told us that they would review incident reports to ensure that all incidents were recorded as being managed under the policy moving forward.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating was given. It is also a requirement that the latest CQC report is published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found that the most recent report was on display in the home and on the provider's web site.