HC-One Limited

Stoneyford Care Home

Inspection report

Stoneyford Road
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Date of inspection visit:
10 August 2016
11 August 2016

Date of publication:
07 September 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 August 2016 and was unannounced.

Accommodation for up to 60 people is provided in the service over two floors. The service is designed to meet the needs of older people living with or without dementia. There were 48 people using the service at the time of our inspection.

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

Risks were not always managed so that people were protected from avoidable harm. Robust systems were not in place to ensure that sufficient staff were on duty to meet people's needs. Medicines management and infection control practices required improvement.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Staff were recruited through safe recruitment practices.

Staff received appropriate induction, training and supervision. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate. However, the environment could be further improved to better support people living with dementia.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People received care that respected their privacy and dignity and promoted their independence.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs, though care plans could be further improved.

A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising any concerns with the registered manager and that appropriate action would be taken.

The provider and registered manager were meeting their regulatory responsibilities and there were effective systems in place to monitor and improve the quality of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks were not always managed so that people were protected from avoidable harm. Robust systems were not in place to ensure that sufficient staff were on duty to meet people's needs. Medicines management and infection control practices required improvement.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. Staff were recruited through safe recruitment practices.

Is the service effective?

Good

The service was effective.

Staff received appropriate induction, training and supervision. People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate. However, the environment could be further improved to better support people living with dementia.

Is the service caring?

Good

The service was caring.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People received care that respected their privacy and dignity and promoted their independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. Care records contained information to support staff to

meet people's individual needs, though care plans could be further improved.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Good

The service was well-led.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising any concerns with the registered manager and that appropriate action would be taken.

The provider and registered manager were meeting their regulatory responsibilities and there were effective systems in place to monitor and improve the quality of the service provided.

Stoneyford Care Home

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.

This inspection took place on 10 and 11 August 2016 and was unannounced.

The inspection team consisted of two inspectors and a specialist nursing advisor with experience of dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent to us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with seven people who used the service, six visiting relatives, a visiting professional, the cook, the administrator, two domestic staff members, a laundry staff member, an activities coordinator, four care staff, a nurse, the registered manager and a representative of the provider. We looked at the relevant parts of the care records of five people who used the service, three staff files and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "I am safe. Everything here makes me feel safe." Another person told us, "I feel safe living here. I'm very happy." A relative said, "[Staff] keep [my family member] safe. Much safer than when [my family member] lived on their own." Another relative told us, "I'm certain that [my family member] is safe."

People did not raise any concerns with us about their safety or the safety of others. People told us they felt able to raise concerns with staff if they did not feel safe.

Staff were aware of safeguarding procedures and the signs of abuse. They said they would report concerns to the registered manager. A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was not available to give guidance to people and their relatives if they had concerns about their safety. The management team agreed to make this information available. Appropriate safeguarding records were kept by the service of any safeguarding referrals they made to the local authority.

Risks were not always managed so that people were protected from avoidable harm and not unnecessarily restricted.

There were pressure relieving mattresses and cushions in place for people at high risk of developing pressure ulcers and they were functioning correctly. However, the firmness of the mattresses had not always been set according to the person's weight and several of the mattresses were set on too firm a setting for the person. This meant that the person was laying on a firmer surface than was appropriate. This increased their risk of developing a pressure ulcer which the mattress has been put into place to avoid. However, people's repositioning charts had been completed to show that staff had supported people to change their position in line with the instructions in their care plan.

Parts of the home were not secure. Access to the home could be gained by unlocked gates on either side of the home. Whilst all other doors to the home were locked and could not be accessed from the outside, when people sat outside in the garden the patio doors were left open. This increased the risk of unauthorised and unsuitable people gaining access to the home. We also saw that sluice rooms had been left unlocked which meant that people who used the service could enter those rooms and access items that might be harmful to them.

We checked the nursing call bells, used by people in their bedrooms if they needed urgent help from staff. Three of the four call bells were in working order and staff responded quickly when we pressed them. However, one call bell was not working. We raised this with the nurse in charge who told us they would speak with the maintenance person to ensure this was fixed immediately.

People did not raise concerns with us about their ability to lead a free and unrestricted life. We observed staff support people when they asked them to assist them with returning to their rooms.

Individual risk assessments had been completed to identify people's risk of falls, developing pressure ulcers, and nutritional risk using recognised risk tools, along with risk assessments for the use of transfer equipment. Risk assessments had been reviewed monthly to ensure they remained an up to date assessment of risk. When bedrails were in use to prevent people falling out of bed risk assessments had been completed to ensure they could be used safely.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans and the involvement of external professionals in order to minimise the risk of re-occurrence. The registered manager told us that falls were analysed to identify patterns and any actions that could be taken to prevent them happening. A person who had fallen frequently had a falls risk assessment in place which was reviewed monthly, a "safe environment assessment" and a falls care plan. A range of measures were in place to reduce the risk of the person falling and to reduce the risk of harm if the person fell. We observed that following falls, vital signs observations had been completed for 24 hours to check for any signs of harm to the person.

We saw that the premises were well maintained and checks of the equipment and premises were taking place. We saw that action was taken promptly when issues were identified from premises and equipment checks.

There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans were in place for all people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

We received mixed feedback from people when we asked them if they thought there were enough staff in place to support them safely. One person said, "There are lots of staff around; when I fell down they were there to help me quickly." However another person described how they had not been offered a hot drink for six hours although they had received a cold drink which they did not like. They also said, "I know they [staff] are busy but I would have liked it [the drink] more often. Normally they [staff] are good, but they do seem very busy today."

Relatives also raised concerns with the staffing levels at the home. One relative said, "A few more staff are needed. There used to be more staff here. They look after [my family member] really well, but there doesn't seem to be the time to sit and talk." Another relative said, "The staff do care, although they don't seem to have the time to give the detailed care they probably should." However one relative said, "There seems to be enough staff, they take the time to talk to people."

A staff member we talked with said they felt additional staff were required to meet people's care needs and that staff always tried to provide care in a timely manner but, "It is tough." Another staff member told us that they enjoyed their work but felt, "Run ragged upstairs. People are not being put at risk but I'd like to spend more time with people." A third staff member said, "We have enough staff but lack efficiency and teamwork." Domestic and laundry staff did not always feel that they had sufficient time to complete their work effectively. In a staff survey in January 2016, a significant proportion of staff did not feel that there was sufficient time and resources to offer activities for people who used the service.

We observed staff responded to people's needs in a timely manner. When people needed assistance with going to the toilet or needed support with eating staff were there to support them. However, we also noted sustained periods of time where people were left with little staff engagement and lounge areas were not

always supervised by staff.

Robust systems were not in place to identify the levels of staff required to meet people's needs safely. A staffing tool was not used to calculate staffing levels and call bell response times were not being monitored to ensure staffing levels were sufficient to meet people's needs in a timely way. The registered manager explained that they considered people's dependencies when setting staffing levels and monitored to ensure that staffing levels remained at the correct level, however, we felt that more robust systems needed to be put in place to ensure that there were sufficient staff to meet people's needs safely at all times.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People told us they were happy with the way their medicines were managed. One person said, "Staff look after my medicines; I'm happy with that." A relative said, "The staff are on the ball with the medicines. They always make sure [my family member] gets them. [My family member] won't always take them. But at their age, I and the staff don't force them to take them if they don't want to." Another relative said, "The medicines process seems ok. I've not identified any issues."

We observed some medicines administration and staff stayed with the person whilst they took their medicines. However, we also found medicines had been left with two people using the service and staff did not observe to ensure that the people took their medicines.

Medicines Administration Records (MAR) contained a photograph of the person to aid identification, a record of any allergies but did not include their preferences for taking their medicines.

One person was receiving medicines that had been prescribed to be given five times a day and it was important that they were given in a timely manner to maximise their efficacy. However, we saw that the fifth dose of the day was prescribed to be given at 22.00hrs but on at least four occasions in the previous three weeks it had been signed as having been given at 20.00hrs and on one day it had been signed as being given at both 20.00hrs and 22.00hrs, indicating an additional dose had been given.

We checked the number of tablets remaining for the person to see if we could identify whether an additional dose had been given but there was a large discrepancy in number of tablets remaining compared to those that should have remained suggesting that either a considerable number of doses had been missed or the total number of tablets at the start of the cycle had been recorded incorrectly. The registered manager advised us that they would be investigating the issue.

Systems were in place for the ordering and supply of people's medicines. We were told people's regular medicines were normally received in time to ensure that people did not miss medicines due to a lack of availability. However, we were told the current order may have been submitted late. We also saw from a MAR that someone had not received a topical cream for three weeks due to being out of stock. Another person's medicine had run out the previous day and they had not been able to receive it, however the pharmacy were contacted and the medicine was delivered the following day.

When people were prescribed to be given medicines only as required, protocols were in place to provide the additional information required to ensure they could be given safely. However, liquid medicines were not always labelled with their date of opening to ensure they were not administered past their expiration date.

Arrangements were in place for the safe storage of medicines. However, on the day of the inspection we found the door of the room used for medicines storage was unlocked. Medicines awaiting return to pharmacy were on the work surface in the room and we were in the room for five minutes without being observed.

While the service was clean, good infection control practices were not always followed. We saw linen stored on the floor of cupboards, cleaning equipment not always stored correctly and the laundry sink area was not tidy and staff would not be able to use it effectively.

Good

Is the service effective?

Our findings

People told us they were happy with the way staff supported them and staff had the skills needed to support them in the way they wanted. One person said, "The staff are alright. They help me if I need it." Another person said, "I like the staff, they try really hard and try to help."

A relative said, "The staff understand [my family member's] ways. They know when [name] wants help and when they don't." Another relative said, "[My family member] has not been here long, but the staff are getting to know [name] and me as well." Another relative said, "They [staff] do seem to know people and what they need." However one relative felt more attention was needed by the staff to make their family member more comfortable when they were in bed. We observed that staff competently supported people during our inspection.

We talked to a visiting professional who told us care had improved over the last three to four months. They said that they had been concerned about care provided on the first floor. However, over the last few months they had had a more positive response from staff, and gave an example of someone who needed to increase their fluid intake and staff had tried a number of different strategies to help with this. They also said they now were given good information about people who used the service from staff. They told us that there were more staff available and this had made a difference.

Staff felt supported by management. They told us they had received an induction which prepared them for their role. Staff also told us they had access to training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role.

Staff told us they received regular supervision. Training records showed that staff attended a wide range of training which included equality and diversity training. Systems were in place to ensure that staff remained up to date with their training and received regular supervision.

People told us they were always given choices by the staff and staff respected their wishes. One person said, "[Staff] don't tell me what to do. They just ask me. They never force me to do anything." Another person said, "[Staff] always ask what I want. They always give you a choice." We saw staff asked permission before assisting people and gave them choices.

The Mental Capacity Act 2005 (MCA) 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 DoLS. We checked whether the service was working within the principles of the MCA.

The requirements of the MCA were being followed. When people were unable to make some decisions for themselves mental capacity assessments and best interest decisions were documented.

When people were being restricted, some DoLS applications had been made. However, only four applications had been made and we advised the registered manager to consider whether they needed to make further applications. The registered manager agreed to do this.

Staff were able to explain how they supported people with behaviours that might challenge others and care records provided clear guidance for staff in this area.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place and they had mostly been fully completed, however, staff agreed to contact the relevant professional to review one DNACPR form that was not fully completed.

People told us they liked the food and drink provided for them. One person said, "The food is good. I get enough. Three meals a day, plus snacks." Another person said, "The food is quite nice. I've been at the home for many years and the food has got better." Another person said, "I had Weetabix for my breakfast. I choose it and I have it every day."

Relatives also spoke positively about the food and drink. One relative said, "The food looks good. [My family member] has a good appetite." Another relative said, "[Staff] bring out tea and coffee quite often. I get offered a drink as well which is nice." However two relatives raised concerns that the menu had been changed without consultation with them or their family member. One relative felt many options now on the menu were not suitable for older people.

We observed the breakfast and lunch meals being served. People were asked what they would like for lunch about one hour before the meal was served. A menu was provided, however this was not available on the tables and was only available in a book in the corner of the room. The menu was provided in text format only, which could make it difficult for people with communication needs to understand.

People received their meals in a timely manner. Where people required assistance from staff with their meals, this was provided. To enable people to eat independently of staff, some people were provided with specially adapted equipment such as double handled cups and beakers with lids.

When staff supported people with their meals they did so in a respectful way. They maintained eye contact with them and did not become distracted. Meals were cleared away from people promptly. People appeared to enjoy their meals. We observed one person described their porridge. They said, "Oh that was gorgeous."

Nutritional risk assessments had been completed and nutrition care plans were in place providing information on people's support requirements when eating and drinking and their individual preferences. Food and fluid charts had been completed to record people's intake and these indicated an adequate intake in the records we reviewed.

People told us they had access to their GP or healthcare professionals if they needed it. One person told us, "If I want to see a doctor they [staff] get one for me and they come to see me." However one relative felt that they had to prompt staff to involve other professionals in their family member's care at times.

Care records contained records of the involvement of other professionals in the person's care, including the

GP, dementia outreach team, speech and language therapist, dietician, optician and chiropodist.

Adaptations had been made to the design of the home to support people living with dementia. Bedrooms, bathrooms, toilets and communal areas were clearly identified. Toilet seats and handrails in bathrooms and corridors were differently coloured to their surroundings so that people with visual difficulties could distinguish them. However, the first floor layout was quite confusing and directional signage would be helpful to provide people with support to walk independently around the home.

Space in the upstairs dining room was limited and it was difficult for staff to move between the tables and provide assistance to people as they ate. The lounge areas on the first floor were also used as thoroughfares for the rest of the floor and did not provide a relaxing environment for people who used the service.

Good

Is the service caring?

Our findings

People told us they felt the staff were kind and caring. One person said, "The staff are very kind, they are really friendly with me." Another person said, "The girls are very good with me. They are very kind and caring."

Relatives also felt the staff were kind and caring. One relative said, "The staff do seem really interested in [my family member]. They are always pleasant and friendly." However, some relatives did raise concerns that they felt their family members would benefit from more attention from the staff, but due to the low staff numbers, they were unable to give them this.

We found that staff were attentive to people's needs and had a good rapport with people. When people were anxious and required reassurance staff provided this in a supportive manner. Staff showed an understanding of the people they cared for and empathy for people.

Staff were very familiar with the people using the service and had a good knowledge of their health conditions and nursing needs. A staff member was able to tell us of the actions which had been taken when people had shown signs of ill health, the plans for their care, and the other professionals who had been consulted and involved.

People told us they felt staff listened to them and acted on their wishes. Relatives told us they were involved with decisions about the family members' care. A relative told us they were asked to meet with the manager to discuss their family member's care. Another relative said that they received regular updates about the family member's care and felt able to give their views.

We spoke with three relatives whose family members were new to the home. They told us they had been involved with the planning of their family member's care and praised the way the registered manager had actively involved them with the decisions. One relative said, "When we came to visit before [my family member] came to the home, we had a good chat with the manager about [my family member's] needs, and the home seemed a really good fit."

We saw that care records contained information which showed that people and their relatives had been involved in their care planning. Care plans contained information regarding people's life history and their preferences and we saw that a person had signed some of their care plans to confirm that they agreed with them.

Advocacy information was available for people in the guide for people who used the service if they required support or advice from an independent person.

When people had difficulties in communicating verbally, communication care plans were in place and provided information for staff on how to understand the person's wishes and strategies staff should use to maximise people's understanding and enable them to indicate their wishes.

One person told us they were having difficulty with hearing out of one of their ears. They had a hearing aid in place. A staff member offered to look at the hearing aid to check the batteries were in working order. The batteries were working, but it was clear the hearing aid had not been cleaned for some time which was affecting the effectiveness of the hearing aid. The staff member cleaned it for the person and they were pleased they could now hear more clearly. We checked this person's care records. There was no care plan in place to ensure the hearing was regularly cleaned. This meant staff were not responding appropriately to this person's communication needs which had a negative impact on their welfare.

We saw some positive examples of staff treating people with dignity and respect. For example where people had spilt food on their clothes, staff responded quickly and offered to help them change their clothes. We also saw staff discreetly talking about people's care needs with each other in order to protect people's right to privacy and to be treated with dignity. However, we also observed a staff member describe a person, loudly in front of others, by saying, "Oh [name], has got their wandering head on today." This phrase, used to describe a person living with dementia could be deemed disrespectful. We also saw a staff member leave people's care records unattended for a period of over thirty minutes which could compromise people's right to privacy.

We saw staff took people to private areas to support them with their personal care and saw staff knocked on people's doors before entering. The home had a number of areas where people could have privacy if they wanted it. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner. Some staff had been identified as dignity champions. A dignity champion is a person who promotes the importance of people being treated with dignity at all times.

People told us they were able to lead as independent a life as possible and we observed people doing so. People were able to make choices such as whether they wanted to sit in the garden and where they wanted to sit for meals and activities. Staff always respected people's wishes and actively encouraged independence. A relative told us the staff respected their family member's right to lead an independent life. They said, "[My family member] is still independent and still makes their own decisions for somethings. For example, even though [my family member] can no longer talk, the staff still ask them questions and now understand when [my family member] is saying no."

We observed that people were supported to eat their meals independently where appropriate. Staff also told us they encouraged people to do as much as possible for themselves to maintain their independence. A staff member said, "You let people do as much as they can, but let them know you're there in case they need help."

People told us their friends and relatives were able to visit them whenever they wanted to. Two of the relatives we spoke with praised the staff for giving them the option of eating a meal with their family members. They told us staff had asked them to give them notice of when they were planning to arrive and a meal would be prepared for them. Both relatives told us they were pleased to be given this opportunity to enable them to spend more social time with their family members

We saw many relatives visiting people throughout the inspection. Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service.

Good

Is the service responsive?

Our findings

We saw that people generally received care that was responsive to their needs. Call bells were answered promptly and staff responded well to people's requests for assistance. However, we observed a person ask a staff member why they had not supported them with shaving after breakfast as they had said they would do. We spoke with the person and they said being clean shaven each day was very important to them. They also said, "I like to have a shave every day if possible, but it doesn't always happen." We checked three hours later to see if the person had received their shave. They had not. We spoke with a staff member and asked them to support the person. By the end of the first day of the inspection we saw this had now been completed.

We observed activities taking place in the downstairs lounge. The activities coordinator included as many people as possible and ensured the game that was being played was played at a pace that all could enjoy. The activities coordinator was engaging and people seemed to enjoy their company. However, we saw only limited activities taking place on the first floor during our inspection.

People told us the staff tried to assist them with following their own interests. One person told us they liked to do word searches and the staff ensured they had books and pencils to do them. Another person told us they liked the bible classes that were provided each week. The person's relative said, "[My family member], went to the bible class last yesterday. They really enjoyed it." Another relative said, "[My family member] enjoys the hymns during bible class." An activities timetable was in place which identified group and 1:1 activities taking place from Monday to Friday. Care staff were generally responsible for activities at the weekend; however, staff on the first floor did not feel that they had always had time to do this effectively. The registered manager told us they were looking to improve activities for people living with dementia.

An initial admission assessment of people's care and support needs had been completed. Care plans were in place which provided information on people's care and support needs. These had been reviewed monthly. Care plans provided personalised information about people's care and support and their preferences. Most care plans provided a good level of detail and were reflective of people's current needs. A care plan was in place for a person who was receiving enteral nutrition and appropriate records were in place to demonstrate the person was receiving the nutrition prescribed and the feeding tube was being cared for as recommended.

However, we found one care plan stated the person required assistance with repositioning four hourly but their daily records did not contain a record of repositioning and stated the person was able to move themselves. As the person remained in bed, was at high risk of developing pressure ulcers (was of a low weight and suffered from involuntary movements), and their bedding came adrift (increasing the risk they would end up laying on creased bed linen) assistance with re-positioning would have been advisable. Another care plan stated a person was fully continent, but they had returned from a hospital admission with a urinary catheter approximately a month previously and this was still in place. Therefore these care plans were not reflective of their needs. The registered manager agreed to review these immediately.

Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs. We saw that people were supported to attend religious activities in line with their preferences. A person who ate a vegetarian diet received appropriate food to meet those needs.

None of the people we spoke with or their relatives had raised a complaint with the registered manager. One person said, "I've no complaints here, but if I did I know they'd sort it." However, all told us they felt able to make a complaint and felt confident it would be acted on.

Complaints had been handled appropriately. Guidance on how to make a complaint was in the guide for people who used the service. There was a clear procedure for staff to follow should a concern be raised.

Staff were aware of the complaints process and the action they should take if a person raised a concern or a complaint. A staff member told us if a person wanted to make a complaint they would listen to their concern and rectify the issue if possible. They would suggest the person should speak to the registered manager and they would report the complaint to the manager themselves. If the manager was not available they would advise the person to put their complaint in writing. They gave an example of a minor complaint from a relative which they had been able to resolve themselves.

Good

Is the service well-led?

Our findings

People and visitors had opportunities to comment on the running of the service. We saw that meetings for people who used the service and visitors took place where comments and suggestions on the quality of the service were made. Actions had been identified and taken in response to any suggestions made.

Two relatives we spoke with told us they had been asked for their views on the development of the service by completing questionnaires. However, they were unsure whether they had received feedback on their answers from the service. We saw surveys had been completed by relatives and visitors. Actions had been taken where appropriate.

A whistleblowing policy was in place and contained appropriate details and staff told us they would be prepared to raise issues using the processes set out in this policy.

The provider's values and philosophy of care were in the guide provided for people who used the service and displayed in the main reception area. Staff were observed to act in line with them during our inspection. A relative said, "There is a nice calm atmosphere. No call bells going off all the time."

The service had links with the local community. A community group met regularly to raise funds for the home and provided volunteers to support the service. The registered manager told us of visits from local schools and churches.

Staff were positive about their roles but told us that not all staff worked well as a team. The registered manager told us that they were supporting staff to work more as a team across the home but acknowledged that more work was required in this area.

People and relatives spoke positively about the new registered manager. A relative said, "The manager was lovely when we first came to the home, she really put us at ease." Another relative said, "I have met the manager and she does seem nice."

Staff were positive about the registered manager. Staff told us the registered manager was supportive and they could discuss issues openly with her. Staff told us staff meetings were held regularly and they were encouraged to raise issues at the meetings. We saw that staff meetings took place and the registered manager had clearly set out her expectations of staff. Staff told us that they received feedback in a constructive way.

A registered manager was in post and she was available during the inspection. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required. The registered manager felt supported by the provider to ensure the service provided a good quality of care for people.

The provider had an effective system to regularly assess and monitor the quality of service that people

received. We saw that regular audits had been completed by the registered manager and also by representatives of the provider. Audits were carried out in the areas of infection control, care records, medication, health and safety, mealtimes and catering. We saw that checks were made to ensure that nurses remained registered with their regulator. Action plans were generally in place where required to address any identified issues, however, clear actions were not always in place when necessary.

We looked at the processes in place for responding to incidents, accidents and complaints. We saw that incident and accident forms were completed. We saw that safeguarding concerns were responded to appropriately and notifications were made to the CQC as required. This meant there were effective arrangements to continually review safeguarding concerns, accidents and incidents and the service learned from this.