Bondcare (Ambassador) Limited

Elton Hall Care Home

Inspection report

Elton Village
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on the 11 February 2016. The inspection was unannounced which meant the staff and registered provider did not know we would be visiting

Elton Hall provides care and accommodation for up to 70 older people, people with dementia and older people with mental health needs. Accommodation is provided over two floors and includes communal lounges and dining areas. Bedrooms are single occupancy and have en suite facilities which consist of a toilet and wash hand basin. At the time of our inspection there were 31 people using the service.

The home had a registered manager in place that started in May 2015. They registered with the Care Quality Commission since 8 February 2016. 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.

At our last inspection April 2015 we found two breaches of regulation. These were in relation to the safety and condition of premises and care being delivered without people's consent.

The registered manager had knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards [DoLS]. The registered manager understood when an application should be made, and how to submit one. Since our last inspection the majority of staff had received training in MCA and DoLS. At the time of our visit there were 13 people living at the service who were subject to a DoLS authorisation.

People had access to medicines and these were stored and administered safely. However a count for one person's medication was incorrect, not all handwritten medication administration records (MAR) had two signatures and there was no record to show that the amount of medication received from the pharmacy for a controlled drug (medicines liable to misuse) was correct. We made a recommendation about medicines management.

Risks to people's health or well-being had been assessed and plans put in place to protect people. However in two people's care files not all risk assessments were reviewed monthly.

People were provided with a meal choice and enjoyed the food on offer. However the dining experience for people living with a dementia needed improving.

Staff we spoke with understood the principles and processes of safeguarding, as well as how to raise a safeguarding alert with the local authority. Staff said they would be confident to whistle blow (raise concerns about the home, staff practices or provider) if the need ever arose.

Accidents and incidents were monitored each month to see if any trends or patterns were identified. At the

time of our inspection the accidents and incidents were too few to identify any trends.

Staff received relevant training and competency assessments took place. Staff received support through supervisions and appraisals

Staff knew people well and were caring and respected people's privacy and dignity.

People were supported to access healthcare professionals and services.

The service had a vacancy for an activities coordinator. Staff were working extra duties to cover activities and this was working well. People were happy with the activities on offer.

People's care records were person centred. Person centred planning provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person.

We found people were cared for by sufficient numbers of staff. Recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

We saw that the service was clean and tidy and there was plenty of personal protection equipment [PPE] available.

Staff were supported by the registered manager and were able to raise any concerns with them.

We saw certificates for safety checks and maintenance which had taken place within the last twelve months such as fire equipment, electrical safety and water temperature checks.

The manager and registered provider carried out regular checks to monitor and improve the quality of the service.

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 always safe
Staff were knowledgeable in recognising signs of potential abuse and knew how to report any concerns.

Assessments were undertaken to identify risks to people using the service and others. Risk assessments were in place but not all were reviewed monthly.

Medicines were stored securely and administered safely. However a count of one person's medicines was incorrect, handwritten MARs did not always have two signatures and controlled drugs were not clearly checked in. We made a recommendation about medicines management.

There were sufficient numbers of staff to care for people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.
Staff had the knowledge and skills to support people who used the service.

People were supported to have their nutritional needs met. However the dining experience on the unit for people living with a dementia needed improvements.

Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards [DoLS] and they understood their responsibilities

People were supported to access healthcare professionals and services.

Is the service caring?

Good

The service was caring.
Staff were caring and respected people's privacy and dignity.

Staff knew people who used the service well.

People's independence was promoted.

Is the service responsive?

Good

The service was responsive.
People's needs were assessed and their care was planned around them. Care plans were person centred.

People were happy with the activities on offer.

A complaints and compliments process was in place

Is the service well-led?

Good

The service was well-led.
Staff said they were supported by their registered manager and felt they were open and honest.

Issues and learning were raised at regular staff meetings.

A wide range of regular audits were completed to monitor and assess the quality of the service provided.

Elton Hall 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 the 11 February 2016 and was unannounced.

The inspection team consisted of one adult social care inspector and one specialist professional advisor (SPA) A specialist professional advisor is someone who has a specialism in the service being inspected such as a nurse

Before our inspection, we reviewed the information we held about the home. We looked at statutory notifications that had been submitted by the home. Statutory notifications include information about important events which the registered provider is required to send us by law. This information was reviewed and used to assist us with our inspection.

The provider was not asked to complete 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.

During the visit we spoke with 12 people who used the service, two relatives, the registered manager, the deputy manager, the administrator, the house keeper, the head cook, the maintenance man and six staff members. We undertook general observations and reviewed relevant records. These included four people's care records, four staff files and other relevant information such as policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2015 we found the premises were not properly maintained. For example, there were uneven pathways which led to the summer house which was used as a smoking shelter, wires were stretched across parts of a lounge at knee height and the grand staircase was open for people to use but there was a sheer drop once the second floor was reached. During this inspection we saw the paving had been re-laid so the pathway was even, wires were no longer at knee height and a gate had been placed on the stairs along with extra railings to keep people safe.

We looked at how medicines were managed. We looked at ten records relating to medication. The service used original packs of medicines and each night did a count of each one. One person had received 30 tablets at the beginning of the month, they had not used any of the tablets, therefore each night the count was still 30. However when we counted them there were only 29 tablets. The missing tablet could not be accounted for. Due to the tablets being loose in a bottle, the tablet could have gone missing during the count. The registered manager said they would arrange for more suitable equipment to be used for counting the medication.

Records were kept of room and fridge temperatures to ensure they were safely kept. Controlled drugs, were stored appropriately. Controlled drugs are medicines liable to misuse. However one person had received 60 controlled drug tablets, loose in a bottle. The service had accepted the controlled drug from the pharmacy but there was no evidence to show these had been checked to see the quantity was correct. This meant if a tablet went missing they could not verify if this was due to a mistake made by the pharmacy or if something had happened in the home. The registered manager was going to put a system in place to make sure this did not happen again.

We observed a lunch time medicine round and we saw staff explain to people what medicine they were taking and why. The senior member of care staff gave people the support and time they needed when taking their medicines. People were offered a drink of water and the senior member of care staff checked that all medicines were taken. The MARs showed that staff recorded when people received their medicines and entries had been initialled by staff to show that they had been administered. MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. Not all handwritten MAR's had two signatures. We recommend the registered provider consults national guidance on medication.

We saw detailed written guidance kept with the MAR charts, for the use of "when required" (PRN) medicines, and when and how these medicines should be administered to people who needed them. This meant that there was written guidance for the use of "when required" medicines and staff were provided with a consistent approach to the administration of this type of medicine.

We saw evidence of topical medicines application records to show the topical preparations people were prescribed, including the instructions for use, associated body maps and the expiry date information. We saw evidence of transdermal patch application records in use to show the transdermal patches people were

prescribed, including the instructions for use and associated body maps.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. We found that the registered manager completed a medicine audit each month followed by an action plan if necessary.

We saw risk assessments had been completed as part of people's care and support plans which identified a range of social and healthcare needs and risks. Risk assessments covered general areas such as medicines compliance, mobility and nutrition. For example one person had a risk assessment in place for smoking and the prevention of smoking in their room. The risk assessment highlighted steps for staff to take to prevent this. Risk assessments also considered the likelihood of pressure ulcers developing or to ensure people were eating and drinking. This meant that risks could be identified and action taken to reduce the risks and keep people safe.

We found that risk assessments, where appropriate, were in place, as identified through the assessment and care planning process, which meant that risks had been identified and minimised to keep people safe. Risk assessments were proportionate and included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. Assessments also considered the likelihood of pressure ulcers developing or to ensure people were eating and drinking. This meant that risks could be identified and action taken to reduce the risks and keep people safe. Standard supporting tools such as the Waterlow Pressure UIcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments. MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition.

The service also promoted positive risk taking. One person who used the service living with a dementia still accessed the local community and shops using public transport. The registered manager said, "We encourage this and provide the person with a card with all relevant details of the home printed on in case the person becomes confused. We know this is very important for this person and we regularly monitor and review it."

People who used the service and relatives we spoke with all said they/their relative felt safe. Staff we spoke with said, "We are very safety conscious." and "People are safe, we look after them and care for them, we make sure they get to places like the smoke room safely and we always make sure people sign in and out."

We looked at the arrangements for safeguarding vulnerable adults. The service had policies and procedures for safeguarding vulnerable adults, whistle blowing, accidents and incidents. Staff understood the different types of abuse that might occur, how to report, escalation of concerns and whistle blowing procedures. They were confident that any safeguarding concerns raised would be dealt with appropriately. Staff were also aware of how to raise concerns with external agencies such as the Local Authority or CQC. One staff member said, "If I saw anything untoward going on I would report it, I would feel comfortable reporting it."

We saw up to date safety checks and certificates for items such as fire equipment, electrical safety and water temperature checks. We saw evidence of Personal Emergency Evacuation Plans [PEEP] for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The service had a 'grab' file for in the event of an emergency which included the PEEPs, a wristband for each person with their name, date of birth and room number, next of kin details and an up to date MAR chart. Fire evacuation took place to cover both day and night staff and we saw records to evidence

this. This meant in the event of an emergency the service was well prepared to continue supporting people. We also asked about how the service planned to provide care in the event of an emergency requiring the building to close for a period of time. We were provided with a business continuity plan which detailed two other homes within the same group close by and the plan incorporated utilising cover between the homes.

Accidents and incidents involving people and staff were appropriately recorded providing information about what happened and remedial actions taken. All accidents were analysed monthly to look for trends or patterns. For example, one person had to move rooms and it was noted that this person had fallen a couple of times. The registered manager changed the furniture around in the room to mirror image the previous room and the falls stopped.

We found people were cared for by sufficient numbers of suitably qualified, skilled and experienced staff. A rota system was in place for all the different staffing groups to ensure there was enough staff on duty. The registered manager also described the flexibility to bring in additional staff if necessary and for staff to stay later on the shift to undertake the administration of medicines, should there be only one senior member of care staff at night. The registered manager told us they did not complete a staffing levels assessment tool, as they based the staffing ratio on a basis of one member of care staff to four people. There was one senior member of staff plus two care staff to cover upstairs and the same downstairs. At night this was reduced to one senior and one carer, upstairs and downstairs. We asked staff if they felt there was enough staff on duty. Staff we spoke with said, "Some days it is fine, other days we are rushed." During our observations staff were very visible and sat and chatted to people or completed paperwork whilst sitting with people.

We looked at the recruitment records for five members of staff. Recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work for example recruitment practices included applications, interviews and references from previous employers. We saw they had obtained references from previous employers and we saw evidence that a Disclosure and Barring Service [DBS] check had been completed before they started work in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

We saw that the service was clean and tidy and personal protection equipment [PPE] was readily available. There was some evidence of wear and tear in furnishings. For example one chair had a rip in it which would make cleaning difficult. A recent survey had also highlighted that some furniture needed replacing. The registered manager had developed an action plan to replace the older, worn furniture.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in April 2015 we found that Mental Capacity assessments were not taking place and consent or best interest meetings did not take place before decisions were made.

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 Deprivation of Liberty Safeguards (DoLS). The registered manager told us they had been working with relevant authorities to apply for DoLS for people who lacked capacity. This ensured they received the care and treatment they needed and there was no less restrictive way of achieving this. At the time of our inspection thirteen people living at the service were subject to a DoLS. Staff had received training in MCA and DoLS and demonstrated an understanding.

During this inspection we saw consent to care and treatment records were signed by people where they were able; if they were unable to sign a relative or representative had signed for them. We also saw where necessary, assessment had been undertaken of people's capacity to make particular decisions. These were decision specific and stated that the assessment covered, "ability to retain information, informed choices on care treatment and daily living, communication". We saw a record of best interest decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them. However one person's care file incorrectly named a mobility assessment as a best interest decision. We pointed this out to the registered manager who said they would discuss with staff and change straight away.

People were supported by staff with the knowledge and skills they required to carry out their role. The registered manager provided information on recent training and we saw certificates in staff files confirmed this had taken place. The registered manager said, "Courses can be viewed live on the internet, or on the DVD library here at the home and requires a multiple choice combined with an evidenced based practise discussion with supervisor prior to the certificate been signed off." The service had also introduced the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life.

Staff received support through regular supervision and appraisals. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. Staff we spoke with said, "I receive regular supervisions about four or five a year and an appraisal. They are good, we sit down and go through topics such as DoLS, MCA, safeguarding and any relevant topics or problems at that time and I get a chance to put my point across." Another member of staff said, "This is a time for me and we discuss lots of things including dress code, time keeping and training."

We were told that new staff undertook a thorough induction process. New staff work supernumerary for three days then buddy up with a more experienced member of staff who they work alongside. New staff were then assessed based on working practices and completed a programme of learning including direct observations from the unit manager or senior carer. This continued for the first six weeks of employment, after which skills and knowledge were assessed in a written exercise.

We observed a lunch time meal both upstairs and downstairs. In the downstairs dining room we observed staff and the registered manager sitting with people and joining in with the meal. People were provided with choice and we saw that they were free to change their mind if they wanted something different. The dining tables downstairs were set with napkins and condiments. However upstairs on the unit for people living with a dementia, tables were not set and pictorial menus were not available to help people visualise planned meals if they no longer understood the written word. We discussed this with the registered manager who said they would make sure condiments, napkins and pictorial menus were always provided.

People were asked for their choices and staff respected these. For example, people were asked where they wanted to sit, where they wanted to eat their meals and what they would like to eat or drink. In addition we saw staff sought consent to help people with their needs. The atmosphere was pleasant and there was some nice conversation between people on the tables. Staff interacted well with people and were available to support people with tasks such as cutting their food up.

The food served was a choice of Shepherd's pie, haddock bake and cabbage and for desert there was a choice of rice pudding and fruit. Where people wanted a further alternative this was provided. However on the unit for people living with a dementia we did not always see staff show people both meal choices. This meant that they would not be able to see and smell the food which was particularly beneficial to people who had a dementia related condition. However, one person was shown the choice of food and their eyes lit up and they came to the dining table immediately. The food was well presented and hot and cold drinks were available.

Where people required encouragement to eat their food staff provided this in a quiet and unhurried way, for example staff sat next to the person and interacted with them in a positive manner to ensure that they had enough to eat. This meant the risk of weight loss was minimised. However, we did observe one member of care staff walk by a person and put food directly into the person's mouth and then walk away, only to return in approximately 10 minutes and do the same again.

We discussed the dining experience with the registered manager and they told us they would address the problems we identified immediately. The registered manager showed us the 'enhancing mealtimes checklist' that was undertaken on a monthly basis by either the registered manager, head cook, maintenance man or family members. We saw from the 'enhancing mealtimes checklist' undertaken on 5 January 2016 that the following observations had been made: "not to deliver medication in restaurant, deliver medication before or after meal service and resident likes to be updated". However the audit did not highlight the problems we identified.

The head chef explained how they received diet notifications which they keep in a file along with information on people's weights. They told us "we get the diet notification sheets and put them in a file and we have just started getting people's weights." The head chef also said, "We are going to start menu displays with pictures and we're just waiting for the display holders". We saw on the 'You Said' board which dealt with feedback the service received from people, "you expressed you wanted more home cooked meals and different food in the menu, compile a new winter menu to try and meet all residents' needs". The head chef told us "We have took all sorts off and put on honey pulled pork as this goes down well, put on fisherman's

pie, pies with pastry tops, we don't have two pies on at one time and we've took off liver as they didn't like it. We have sherry, soft drinks and nibbles now and then about once a month, we have different cake varieties in the afternoon, we do fish finger sandwiches and spaghetti hoops on toast as they like that."

People we spoke with were complimentary about the food. One person said, "Food could not be nicer." Another person said, "I have just had pasta bake, I have never had that before, it was very nice." And another person laughingly said, "It's a good it's a like mama used to make."

A relative we spoke with said, "We are always invited to eat and often enjoy a meal together."

Health monitoring was in place such as weekly or monthly weight recording, if weight loss was 2 kilogram or more an action plan was put in place. This information was used to update and make referrals to relevant health care professionals, such as General Practitioners (GPs), dieticians and speech and language therapists (SALT), for advice and guidance to help identify the cause.

We saw evidence of involvement of other health and social care professionals involved in care. People's records showed details of appointments with and visits by healthcare and social professionals and we saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example GPs, social workers, safeguarding team, dietician, speech and language team, tissue viability nurses, continence nurses and chiropodist. Care plans reflected the advice and guidance provided by external health and social care professionals. On the day of inspection one person had visited the dentist.

Good

Is the service caring?

Our findings

There was a calm, positive atmosphere throughout our inspection and we saw that people's requests for assistance were answered promptly. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, respectful, supportive and encouraging.

People were asked what they wanted to do and staff listened. In addition, we observed staff explaining what they were doing when they were supporting people, for example in relation to medication. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

Staff were patient, kind and polite with people who used the service and their relatives. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and were able to describe people's care preferences and routines. Overall, people looked clean, comfortable and well cared for, with evidence that personal care had been attended to and individual needs respected.

We asked people who used the service what they thought of the staff. One person said, "Oh the staff are very nice. " Another person said, "The staff are all very kind and caring." Relatives we spoke with said, "Staff are super." And another said, "Staff are excellent especially [staff member's name]."

Staff we spoke with said, "Working here is absolutely wonderful, it is so rewarding, I feel I am achieving more daily." and "We are like one big family."

Care plans detailed what the person was able to do to take part in their care and to maintain some independence. We were told by staff that independence was fully encouraged. One staff member said, "If people are capable of doing something themselves we let them and if they need assistance we ask them if they want help."

We saw through observation that people were treated with dignity and respect. Our observation showed staff were respectful when talking with people calling them by their preferred names. We observed staff knocking on doors and waiting before entering, ensuring people's privacy was respected. Staff we spoke with said, "I always make sure bathroom doors are locked, I talk through what I am going to be doing." and "I knock on the doors and wait for an answer." Another staff member said, "I always knock on the door, introduce myself." The housekeeper said, "If they don't want me to go their room, I won't go in their room, it's their choice. I would go back later or at a preferred time to clean."

We observed staff support one person who was becoming distressed. This person wanted to carry out a certain task saying they needed to do it immediately. We saw a staff member reassure the person and gently took them away to carry out the task; the person became calm and relaxed.

We saw detailed records of people's end of life care preferences. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions for people and we saw that the correct form had been used

and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

Information on advocates was available, however nobody was using an advocate at the time of the inspection. Advocates help to ensure that people's views and preferences are heard.

Good

Is the service responsive?

Our findings

At this inspection we looked at four care plans and saw they were person centred and addressed a wide range of people's needs. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. Staff were aware of people's needs and preferences and demonstrated their knowledge in conversations with us.

A personal care plan for people's individual daily needs such as mobility, personal hygiene, nutrition and health needs was written using the results of the risk assessment. Staff knew the individual care and support needs of people, and this was reflected in people's care plans. The care plans gave staff specific information about how the person's care needs were to be met and gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They also detailed what the person was able to do to take part in their care and to maintain some independence. People therefore had individual and specific care plans to ensure consistent care and support was provided. The care plans were regularly reviewed to ensure people's needs were met and relevant changes added to individual care plans. Overall, care plans were detailed and provided us with evidence that people received skilled, empathetic care, to enhance their wellbeing.

The deputy manager said, "We've pulled the care plans apart, the best staff members are left, it's a heck of a difference, we've archived stuff, all care plans are individual and recent now"

Each person's care plan contained a social profile ('This is my life, This is me'), where the information had been collected with the person and their family and gave details about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle. This meant that staff had important information about the person when the person could no longer tell staff themselves about their preferences and enables staff to better respond to the person's needs and enhance their enjoyment of life.

Concise daily notes were kept for each person, and information was recorded regarding basic care, hygiene, continence, mobility, nutrition, activities and interests. This was necessary to ensure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People were provided with choice, such as where they wanted to sit, spend their day, what food they wanted, clothes they want to wear. Some people chose to sleep late and we saw people having breakfast at about 10:30am. One staff member said, "It is up to them, they can go to bed when they want, get up when they want it is their choice."

At the time of our inspection Elton Hall had a vacancy for an activities coordinator, the previous activity coordinator left in January 2016. Staff were working extra activity shifts to cover activities. One staff member said, "We do as much as we can and we are trying to do more activities." We were shown an activity file which evidenced all activities that took place, such as a fete, raffles, singers coffee mornings, pet dogs and church. The service had hen power which came in every week to do activities such as singing. Hen power is a project for care homes such as Elton Hall to establish hen keeping in order to provide meaningful activities.

Hen power meets the costs of setting up a hen house, run etc. and also continue to meet the costs of feed and bedding for a further six months. They also provide six weeks of activities such as music therapy, art and gardening. We were told some people who wanted, were going to help paint the hen house and they were also going to have naming ceremonies for the hens. People living on the dementia unit enjoyed going out and seeing the hens and we saw this taking place on the inspection day. Another staff member said, "We paint, do puzzle books, read books or just sit and chat daily." We observed staff sitting and chatting with people throughout the day. People we spoke with were happy with what activities were taking place. One person said, "I like the chair exercises." There were two lounges downstairs, one was a quiet lounge where people could sit and listen to music, the other had a television. The upstairs lounge had comfortable settees and a homely atmosphere and one person was enjoying a game of dominoes.

We looked at the service's complaint's procedure. The service had received about three complaints since our last inspection. We saw complaints received were dated, and recorded the name of the complainant, the complaint, who dealt with it and the date resolved. One complaint was in the process of being investigated and we were made aware of this and the registered managers next steps. People felt able to raise issues with the registered manager. One relative we spoke with said, "I have no complaints but would know what to do if I did."

Good

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager who had been registered with the Care Quality Commission since February 2016. They had been working in the post of manager since May 2015.

Quality assurance audits were regularly undertaken to assess and monitor the quality of the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. We saw evidence of weekly and monthly audits carried out by both staff and the registered manager, as kitchen audits, infection control audits and medication audits. The area manager also carried out a monthly audit. The area manager audit looks at all aspects of the service including falls, weights, pressure areas, health and safety, maintenance, medication, cleanliness, care files, audit's, complaints and commendations, safeguarding, supervision and appraisals, staff suspension and disciplinary. The audit was scored and the percentages rated on the score. The last audit was scored at 83% and we saw evidence of an action plan for areas that were not compliant. The registered manager explained how they sit with the management team and discuss the audit and talk about areas of improvement and where they need to develop the service. The registered manager also shared this with the seniors and staff at the team meetings to inform and improve practise within the home. This meant that the registered provider was analysing information about the quality and safety of the service.

The registered provider sought and acted on feedback from relatives and staff. They completed a staff and relatives survey. The staff survey showed that staff felt they were provided with good training and provided good care. The relatives survey showed that overall people were happy and suggestions they made were put on a board in reception, along with a summary of how the service had responded. Suggestions included change of menu, different activities and queries regarding who people's key workers were. The registered provider had also sent a professionals survey out but at the time of inspection no replies had been received.

We asked relatives what they thought of the service, the registered manager and the staff. One relative said, "I am always made to feel really welcome, anytime I arrive. All staff are very good and very good at communicating with me." and "The staff are very helpful and keep me fully informed; they call me every week to update me."

We asked staff if they felt supported by the registered manager. Staff we spoke with said, "The manager has pulled this place around, it was going astray, [the registered manager] is a good manager and does not suffer fools." Another said, "[the registered managers] has made absolutely massive improvements, I am much happier working here Staff now want to be here it is a much happier place" And another person said, "[the registered manager] is very supportive and approachable, they have made difference, staff are more interested. " One staff member said, "[the registered manager] is leading the team better, it is so much better, it's been wonderful, I could not have asked for a better manager to turn this place around."

We asked the registered manager how they promoted the services visions and values. They said, "I do this through training and development and leading by example. I make sure I have a presence in the home,

make sure everyone knows who I am and provide them with help and support."

Staff we spoke with thought that the service had an open and honest culture. One staff member said, "I trust the manager wholeheartedly." Another staff member said, "I think everyone, staff, residents etc. are honest and trustworthy."

We saw records to confirm that staff meetings took place on average every two months. Topics discussed were holidays, rotas, infection control, meals and mobile phones. Staff we spoke with said, "Staff meetings are good, any issues we raise are dealt with promptly." Another staff member said, "Meetings are good, especially now the staff want to be here and are more involved."

We saw evidence of meetings for people who used the service and their relatives taking place. Topics discussed at these meetings were, activities, food, positive risk taking and infection control.

We saw the service had links with the local community such as the church. We were told the pharmacy have come to the service in to do a pamper event for all the people using the service.

The law requires providers send notifications of changes, events or incidents at the home to the Care Quality Commission and the registered provider had complied with this regulation.