HICA

Parklands - Care Home

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 03 May 2016. The inspection was unannounced. We previously visited the service on 11 December 2013 and we found that the registered provider met the regulations we assessed.

Parklands care home provides residential care for up to 30 older people and people who may have a dementia related condition. It is situated in the village of Rawcliffe, five miles from the town of Goole, in the East Riding of Yorkshire.

The registered provider is required to have a registered manager in post and on the day of the inspection, there was a manager in post. However, they were not currently registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. Although routine notifications were being made, we found one example where the manager had failed to notify the CQC of a significant event. We made a recommendation about this in the report.

There were systems in place to manage people's comments and complaints and there were opportunities to seek feedback from people and their relatives about the service provided. However, we found that the recording of complaints was inconsistent and that the home had no record of a recent complaint made about the service. We made a recommendation about this in the report.

We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes. We found that people's needs were assessed and risk assessments put in place to keep people using the service and staff safe from avoidable harm. The service had a robust system in place for ordering, administering and disposing of medicines.

We saw that staff completed an induction process and they had received a wide range of training, which covered topics including safeguarding, moving and handling and infection control. Staff told us they felt well supported; they received supervision, appraisals and attended team meetings. Staff received training on the Mental Capacity Act 2005 and had knowledge sufficient for their role.

The manager understood the Deprivation of Liberty Safeguards (DoLS) and we found that the Mental Capacity Act (MCA) (2005) guidelines had been followed. The home did not use restraint but the manager understood the process to ensure that any restraint was lawful.

People told us that the staff were caring and they felt well looked after. We saw people were treated with respect and dignity and saw examples of positive interactions between the staff and people living in the home.

People had their health and social care needs assessed and care and support was planned and delivered in line with their individual care needs. Care plans were individualised to include preferences, likes and dislikes and contained detailed information about how each person should be supported. People were offered a variety of different activities.

We found the registered provider had audits in place to check that the systems at the home were being followed and people were receiving appropriate care and support.

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.

Staff displayed a good understanding of the different types of abuse and had received training in how to recognise and respond to signs of abuse to keep people safe from harm.

Risk assessments were in place and reviewed regularly which meant they reflected the needs of people living in the home. There were sufficient numbers of staff employed to ensure people received the support they required.

The home had a robust system in place for ordering, administering and disposing of medicines.

Is the service effective?

Good

The service was effective.

Staff had received an induction and training in key topics that enabled them to effectively carry out their role.

The manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and we found the Mental Capacity Act 2005 (MCA) guidelines were being followed.

People enjoyed a good choice of food and drink and were provided with regular snacks and refreshments throughout the day. People told us they enjoyed the food.

People who used the service received, where required, additional treatment from healthcare professionals in the community.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection.

People were treated with respect and staff were knowledgeable about people's support needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a complaints procedure in place and people knew how to make a complaint if they were dissatisfied with the service provided. However, the recording of complaints was inconsistent.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people.

We saw people were encouraged and supported to take part in a range of activities.

Is the service well-led?

Good

The service was well-led.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. Although notifications were submitted, we found one example where the manager had failed to notify CQC of a DoLS authorisation.

The service had effective systems in place to monitor and improve the quality of the service.

Staff and people who visited the service told us they found the manager to be supportive and felt able to approach them if they needed to.

There were sufficient opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

Parklands - 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 registered 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 was carried out on 3 May 2016 and following the receipt of some information of concern was revisited on 7 July 2016. Both visits were unannounced. One Adult Social Care (ASC) inspector carried out the inspection.

Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commissioned a service from the home. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home. They did not have any concerns about Parklands at the time of this visit.

The registered provider was asked to submit a Provider Information Return (PIR) prior to the inspection, as this was a planned inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider submitted their PIR in the agreed timescale.

During the inspection, we spoke with three members of staff, the manager, five people who used the service, two healthcare professionals and three relatives. We spent time observing the interaction between people who lived at the home, the staff and any visitors.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people, medication records for five people, handover records, supervision and training records for three members of staff and quality assurance audits and action plans.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe, one person said, "The staff make sure I am safe. They know I like to stay up and watch TV, so they come in and check on me and see if I want a cup of tea." Another told us, "It's safe and we all get looked after." A visitor told us, "Yes, people are safe, they are well looked after."

The home had policies and procedures in place to guide staff in safeguarding people from abuse. We saw the manager used the local authorities safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We saw that safeguarding concerns were recorded and submitted to both the local safeguarding team and the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report these types of incidents.

We spoke to staff about safeguarding, how they would identify abuse and the steps they would take if they witnessed abuse. The staff provided us with appropriate responses and told us that they would initially report any incidents to either the senior member of staff on shift, or the manager. They also told us they knew how to escalate their concerns if they felt the issue had not been appropriately addressed. Staff told us, "I've never seen anything of concern whilst I've worked here. If I did I would go straight to the senior, manager or higher if needed." Another said, "I would use the safeguarding matrix to decide if I needed to contact the safeguarding team or speak with the manager. If I felt my concerns were not taken seriously I would go straight to the safeguarding team myself."

We saw the home had systems in place to ensure that risks were minimised. Care plans contained risk assessments that were individual to each person's specific needs. This included an assessment of risk for falls, pressure care, mobility and nutritional status. Staff told us they carried out regular checks of the home to ensure that fire exits were clear, floors were free from trip hazards and they were aware of people's whereabouts in and around the home. All bedrooms had a 'nurse call', that enabled people using the service to summon assistance if needed. We did note that for people living with a memory impairment that these may not always be clearly identifiable. The deputy manager explained they would develop some additional signage to ensure all people knew how to call for assistance. We saw Personal Emergency Evacuation Plans (PEEP) were in place 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 they need to assist people to evacuate the premises safely during an emergency. This showed the manager had taken steps to reduce the level of risk people were exposed to.

All accidents and incidents were collated, accurately recorded and included information of what action had been taken and which external agencies had been notified. Following an accident a 72-hour care plan was implemented; this provided prompts for the staff to carry out increased observations and notify the appropriate health care professional should the person experience any deterioration in health or a change in their usual behaviour. These were audited on a monthly basis and submitted to the regional manager for further analysis. This provided opportunity for the manager and regional manager to monitor whether any patterns were developing and put in appropriate interventions to minimise the risk of them occurring again.

For example, we saw that one person had fallen from their bed on a number of occasions. We saw that a risk assessment had been implemented and this included the use of a 'crash mat' to prevent any injury should the person experience another fall. We noted that some of the incident reports did not always provide a full account of what had happened prior to the incidents occurring. This would enable the manager to assess what had triggered a particular type of incident and look at ways to prevent reoccurrence.

We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, the kitchen equipment, fire extinguishers, emergency lighting and all lifting equipment including the passenger lift, hoists, baths and slings. We saw that a suitable fire risk assessment was in place and regular checks of the fire alarm were carried out to ensure that it was in a safe working order. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

We spoke with the manager about how they ensured there was enough staff on duty to safely meet people needs. The manager told us the service had previously being overly reliant on agency staff, however this had now improved and the staff group was more stable. They also told us that the number of staff required was determined by the needs of the people using the service and was adjusted accordingly. On the day of this inspection, there was the manager, deputy manager, one senior carer, four members of care staff, a cook, a kitchen assistant and a member of domestic staff on duty; during the afternoon, there was also an activity coordinator on duty. We checked rotas and found that on a night there was a senior carer and two members of care staff on duty. One person we spoke with told us, "Whatever time I get up, there is a member of staff there to help me within two minutes." Another said, "The staff come as quickly as they can, it depends on what else is going on at the time. We don't wait long, it's not an issue." Our observations confirmed there were sufficient levels of staff to meet the needs of the people using the service.

We looked at the recruitment records for three staff members. We found the recruitment process was robust and all employment checks had been completed. Application forms were completed, references obtained and checks made with the Disclosure and Barring Service (DBS). The DBS 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 ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions and terms and conditions of employment. This helped to ensure staff knew what was expected of them.

We were told that only the management team and seniors carers received training in the administration of medication and checks of the training records confirmed this. We found the service used a monitored dosage system supplied by a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for simple administration of medication at each dosage time without the need for staff to count tablets or decide which ones need to be taken and when.

We looked at how medicines were managed within the home and checked a selection of people's medication administration records (MARs). We saw that medicines were obtained in a timely way so that people did not run out of them, administered on time, recorded correctly, stored safely and disposed of appropriately. We saw that medication was stored securely in a locked cabinet and that there were facilities available to store controlled drugs (CDs). These are medicines that have strict legal controls to govern how they are prescribed, stored and administered. We saw that daily temperatures of the medication fridge and air temperature of the medication room were monitored and recorded and these were within safe limits.

Medication audits were completed on a regular basis and this helped to identify any errors at the earliest opportunity.

During the inspection, we found the home to be clean, tidy and free from odour. Infection control audits were completed on a monthly basis and we saw that there was detailed information available for staff on hand washing, mattress care and what to do in the event of an outbreak or suspected outbreak of an infectious disease within the home. Cleaning schedules included daily, weekly and deep cleaning tasks to be completed by the domestic and night staff. This showed us that the manager had considered the impact of infection for people in the home and had put interventions in place to minimise this risk.

Good

Is the service effective?

Our findings

Staff told us they completed a thorough induction held at the registered providers head office prior to starting working within the home. One member of staff told us, "The induction was the best training I have ever been on." The induction included training in moving and handling, safeguarding vulnerable adults, fire awareness, infection control and health and safety. As part of the induction process, staff had the opportunity to shadow more experienced members of staff working in the home before they were included as a staff member on the rota. On the completion of their induction, staff then began working towards the care certificate, which they completed over a 12-week period. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Care workers were then enrolled on the NVQ Level 2 in care.

We viewed training records and saw that staff received on-going training and that this was mostly up to date, however we did note that some training in safeguarding of vulnerable adults required updating. We discussed this with the manager who told us that, where gaps in training had been identified, refresher training was already booked. We could see from the training records that all of the staff received the same training irrespective of what their role in the home was. This helped ensure that staff had the necessary skills to carry out their roles and were kept up to date in any changes in practice or legislation.

The staff we spoke with told us they received supervision either from a senior care worker or from the manager. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. It is important staff receive regular supervision as this provides an opportunity to discuss people's care needs, identify any training or development opportunities for staff and to address any concerns or issues regarding practice. Staff also told us they attended regular team meetings and they found these were useful and a good opportunity to raise any concerns.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We found one person using the service was subject to a DoLS authorisation and the manager was awaiting the outcome of additional applications that had been made to the local authority. The Care Quality Commission monitors the operation of the DoLS, which applies to care services, and registered managers are required to notify the CQC of all DoLS authorisations. Prior to the inspection, we had noted that no notifications had been received from the service. This was addressed in the 'Well led' section of this report.

Staff told us they had completed MCA training and records we saw confirmed this, although some staff required refresher training. During our discussions with staff, we found that they had the appropriate levels

of knowledge regarding MCA for their roles. Staff also explained how they requested consent before carrying out any care tasks, by asking people for permission and talking them through each step of the care intervention. The manager told us that restraint was not used in the home and the staff we spoke with supported this.

People using the service told us they enjoyed the food and looked forward to meal times. Comments included, "The food is lovely, I cannot grumble", "We're having steak and chicken today. You don't' need a knife for the steak, it just falls apart" and "We always have a variety and it's very tasty."

We observed the serving of lunch and found it was a pleasant, relaxed and unhurried experience. Most of the people using the service chose to eat in the main dining room, whilst others chose to eat in one of the lounges or alternatively in their own room. People were helped to their seat just before lunchtime, which meant they did not have to wait long for their meal to be served. Aprons were provided to protect people's clothing from any spillages and we saw that tables were set with tablecloths, placemats, napkins and cutlery and condiments were available on each table.

There were sufficient numbers of staff serving food and supporting people in the dining room and this meant meals were served in a timely manner, which prevented food from getting cold. People were offered a choice of starter, main course, dessert and a choice of hot and cold drinks. Staff spoke with people in a respectful manner and explained what the meal was, checking it was what the person had requested before serving the next person. We saw that people who required assistance to eat and drink received this in a dignified manner. Staff sat alongside people and spoke to them throughout, providing encouragement and prompts as required.

We spent time talking with the cook. They explained their shift pattern enabled them to prepare a teatime meal almost too each person's individual requirements. This pleased one person who used the service who told us, "Guess what I am having for my tea...two soft boiled eggs and soldiers. I had to sign a form to say I could have them soft. They are lovely." Another told us, "I just happened to mention that prawn sandwiches were my favourite and within a few days they were on the menu, I'm spoilt."

We saw that the kitchen had cleaning schedules in place and that the temperature of fridges and food was taken daily. The home had achieved a rating of five following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score achievable.

People's health needs were supported and were kept under review. We saw from care records that people had detailed information recorded regarding their health and that other professionals were involved in people's care, for example their GP, social worker, psychiatrist or dietician. A member of staff told us, "We can tell when people are unwell and if we have any concerns we call the doctor out straight away. The GP usually comes out quickly." We spoke with one health and social care professional who had visited the home on a regular basis. They told us "Staff are knowledgeable about people's needs, likes and dislikes. They are generally good at following advice and they show an interest in the treatment of people's ailments."

We noted that during the morning some areas of the home appeared to be overly warm. Although this did not appear to be of concern to the people using the service it was mentioned by staff and visitors. We discussed this with the manger, who told us that the heating system in place did not enable them to control the temperature of each room separately. However, they were able to control the temperature through ensuring rooms ventilated if they felt they were becoming too warm. The temperature in the home did drop

throughout the day to a more comfortable level. On the second day of this inspection we found the temperature of the home to be more comfortable. Daily room temperatures were now recorded to enable staff to take action if they detected a room was too warm or too cold.

Good

Is the service caring?

Our findings

All of the people we spoke with told us that they were happy and felt well cared for. Comments included, "The way the staff look after me is wonderful. They always look out for me. One of the staff always gives me a kiss and a cuddle which shows they care", "My bed is made every day and the food is delightful", " and, "The personal care is always spot on." A visiting relative told us, "The staff are always nice and polite."

We spent time observing people who used the service and saw how they interacted with staff and other people living in the home. We saw that the frequency of staff interaction with people living in the home was a little inconsistent. For example, we saw that people were fully engaged during activities, drinks rounds and mealtimes, however, at other times we saw that people had short periods with little interaction from the staff team. We saw that there were some missed opportunities from staff to engage with people using the service, although, these did coincide with those periods of the day when staff were at their busiest. For example, following mealtimes when high numbers of people required the use of the toilet or during medications rounds. We discussed this with the deputy manager and they told us that they would raise this as an area for discussion at the next team meeting to ensure staff were interacting with people when possible.

We saw that most people appeared to be relaxed and happy in their environment. Staff were knowledgeable about people's needs. They told us they could read people's care plans and that these included information that helped them to get to know the person, such as their hobbies and interests, their family relationships, their likes and dislikes and their usual daily routine. We saw people were comfortable in the company of staff and were able to share a laugh and a joke. People using the service were happy to approach staff and ask for support and staff knew how to respond.

Staff told us they continually promoted the independence of people using the service. One staff member told us, "I encourage people to do as much as possible for themselves. If they are able to wash their hands and face for themselves then I let them get on with it." We saw care plans provided information regarding what tasks people were able to carry out for themselves and where support was required from staff this was clearly detailed. One care plan we viewed advised staff to encourage the person using the service to try and complete tasks for themselves before staff intervened. It also acknowledged that the person could become agitated if staff did not follow this advice. A visiting healthcare professional told us that one person, who they previously supported in the community, had settled in the home very well. They told us that when they visited the service they had seen the person helping the handy man out with his daily checks. This showed that people were encouraged to maintain their independence.

People told us they were given a choice about how their care was provided. They told us they were able to choose what time they got up in the morning and what time they went to bed. They told us they were given a choice of meals, where they sat and whom they spent their time with. They also said they were able to decide what activities they wanted to join in with and were asked whether they preferred a male or female carer to support them. One person using the service told us, "I can get up when I want and come and go to my room as I like. I have my own key and keep my door locked when I am not in it to stop anyone wandering

in. I like to be down in the lounges, so usually come back to my room at about 8pm."

Relatives and visitors were welcome at the home and were free to come and go as they pleased and stay as long as they liked. They were, however, discouraged from visiting people in the dining room during mealtimes, but we saw that people could choose to eat and spend time with their family in other areas during this time if they wished. Some family members and friends chose to spend time in the home with their relatives, whilst others liked to take people out for lunch or to do some shopping in the town. One relative told us, "I'm always made to feel welcome" and one person who used the service said, "My daughter is always made to feel very welcome when she visits."

People were treated with dignity and respect. We saw that staff knocked on people's doors before entering, called people by their preferred name and ensured bathroom doors were closed quickly if they needed to enter or exit, so that people were not seen in an undignified situation. They also ensured that they did not provide any care considered personal in the communal areas. A visiting healthcare professional told us, "The staff make sure people are alright, they treat them with respect which is what really counts."

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Requires Improvement

Is the service responsive?

Our findings

As part of the admission process an assessment was completed to ensure the home was able to meet the needs of the person. We saw that the information gathered during this initial 'focus' assessment was taken from a number of sources, including people's families and also from local authority support plans where relevant. This information was used to determine people's dependency levels and more detailed care and support plans and risk assessments were then developed. This included, for example, information on a person's mobility, nutritional needs, personal care, skin integrity, sleeping, capacity, pain and medication. We also saw that people had specific plans in place for their personal circumstances, for example, the use of a wheelchair or bed rails.

Care files included life maps, patient passports and lifestyle profiles, which described in detail the person's normal daily routines, such as what time people usually liked to be woken up, what they liked for breakfast and whether they woke throughout the night. Life maps included detail regarding people's previous occupation, where they used to live and described which people were important to them. Patient passports explained how to care for people should they be admitted to hospital. These are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff, and describe their individual requirements for support.

One person we spoke with told us that no assessment of their relatives needs had been carried out prior to their admission to the service for a period of respite. We discussed this with the deputy manager and they were able to provide us with the person's care file. We saw that the service had completed the initial focus assessment by liaising with the person's social worker. A comprehensive care plan was developed that including personal plans for washing and dressing, mental state and cognition, medication, pain, communication, elimination and eating and drinking (including additional information regarding the person's gastric condition). A PEEP and a map of life had also been developed and information was available regarding the persons likes and dislikes. We discussed the need to ensure that people's representatives were fully involved in the planning of care (if that was the person's choice) with the senior staff member who completed the assessment. They told us they had contacted the family regarding some specific issues such as whether the person wore glasses, but acknowledged they could have used that as an opportunity to discuss the care plan as a whole.

Some people could not recall being involved in the development of their care plan, with one person stating, "I've not seen my care plan from what I can remember." However, looking at the information that had been collated regarding each person it was evident that consultation had taken place with either themselves, a member of their family, or a social services representative.

We saw that people were occupied throughout the day with a variety of activities taking place at different times. The service employed activity coordinators and they were responsible for ensuring that people were engaged in meaningful activity. We saw that they usually worked during the afternoon shift, although activities still took place during the morning. For example, on the day of this inspection a local church group was providing entertainment for people who used the service. This was well attended and people clearly

enjoyed the singing and storytelling. One person using the service told us, "This morning the local church have been in singing songs and telling stories" and "Some of us have had out feet done by the chiropodist." Another person told us, "There are two girls who find things for us to do. We do quizzes, bingo and jigsaws."

People spoke of the different entertainers that came into the home and they were excited about the planned visit of an Elvis Pressley impersonator. One person said, "We've got an Elvis Pressley impersonator coming in soon, and I've had a sing along this morning." Other activities on offer included games such as indoor skittles, dominoes, cards and bingo. One person said, "We play Bingo, my daughter comes and joins in, last time we played I won some chocolate."

The manager explained that a number of people using the service particularly enjoyed arts and crafts. We saw birthday cards had been made to sell to raise funds to purchase additional activity resources. 'Twiddle Muffs' had also being knitted by some of the people using the service and were used by people with a dementia related condition. Twiddle muffs are a knitted muff with items attached; they provide a source of visual, tactile and sensory stimulation and help alleviate restless hands and keep people occupied. A pop up shop had been purchased and plans were in pace to turn this into a fully functioning shop to enable people to purchase sweets, chocolates and crisps and also other items including toiletries, with all proceeds going back into the activity fund.

There were a number of different seating areas available and there was free access to two secure outdoor spaces. We saw there were raised beds, planters and bird feeders in the garden to provide activities and stimulus for people using the service. However, it was noted that the grass in the garden area was in need of cutting to make it more useable, although on the second day of this inspection we saw the garden was well maintained.

We saw that people were encouraged to maintain positive relationships with members of their own family, their friends and the people they lived with. There were different areas within the home for people to sit in and we saw that people with similar interests chose to sit and spend time together and had become friends. This was actively encouraged by the staff who had learnt the routines of people and were able to ensure that these friendships were appropriately supported.

All of the people we spoke with told us they knew how to make a complaint and had confidence that it would be appropriately followed up. One person said, "If I had any problems then I would speak with the gaffer and tell them." Staff told us they knew how to manage complaints and one member of staff told us, "I've never received any complaints; if I did, I could look at the complaints procedure or just speak with the manager." Another said, "If the complaint was against the manager I would speak with head office and let them investigate this."

We saw there were policies and procedures in place to ensure that all complaints were dealt with in a satisfactory manner. A copy of the complaints procedure was included in the service user guide that was given to people and their families. We viewed the complaints file and found that the service had not received any complaints within the past 12 months. However, following the first day of this inspection we received a number of concerns from a relative regarding the care and support their family member had received during the time they were supported at the service. We checked the complaints file and found no record of this complaint. We addressed this with the deputy manager who explained that the complainant had not wanted to make a formal complaint therefore the matter had been managed by themselves. We discussed the need to ensure that both verbal and written complaints were accurately recorded, including any action taken by the service and whether this was to the satisfaction of the complainant. This would enable the service to reflect on any concerns raised, look for patterns and put plans in place to minimise any

recurrence. We have asked the registered provider to look at the concerns raised further so that they can be appropriately responded to.

We recommend the service seek advice and guidance on the management of complaints.

We saw that people were encouraged to offer feedback, share their experience or raise concerns. Meetings were help for people using the service, quality surveys were distributed and the manager operated an open door policy, which enabled both people using the service and staff to speak with them at any time. The manager had also established 'manager surgeries' that were open to people using the service and their relatives. This provided a further opportunity for people to discuss any concerns or raise any issues they may have. A suggestion box was in place in the homes entrance, although we found the sign asking people to make comments had been covered by the signing in book, which may have contributed to the lack of suggestions made so far.

Good

Is the service well-led?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services and it is a requirement of the registered manager to ensure that the CQC is notified of all DoLS authorisations. We found one example where the manager had not submitted a DoLS notification. However, the manager of the service had informed the CQC of all other significant events in a timely way. This meant we could check that appropriate action had been taken.

We recommend that the service reviews their process for submitting all required notifications.

The home is required to have a registered manager in post. A registered manager is a person who has registered with 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. On the day of the inspection, there was a manager in post. However, they were not currently registered with the CQC. We discussed this with the manager and they told us that they were still in the process of obtaining the relevant DBS documentation and once this had been received, they would submit the required application to be registered.

People told us the manager was approachable, knew the people using the service well and put people using the service first. A visiting health care professional told us, "The manager is familiar with all the residents and spends time interacting with them. They seem to enjoy his company as well." One person using the service told us, "The manager is always up and down, pops their head in and checks that we are all ok." However another said, "I see him now and again, but not everyday." A member of staff told us, "The manager is very approachable and always available if you want to speak with them. You know where you stand with [Name of manager] and what they expect." People also felt they had noticed improvements to the service since the manager had been appointed. One person told us, "It's changed over the years, it's much cleaner than before" and another said, "The home has definitely improved, there's been lots of changes." A member of staff told us, "We needed new bedding and discussed this with the manager and we've got it now, so things have improved."

There was a quality monitoring system in place that consisted of weekly, monthly and annual audit tasks, as well as records of meetings, questionnaires and analysis of the information collated from these. Action plans had been produced to address any areas identified as requiring improvement. For example, we saw that audits of the care plans had identified that some staff had not updated the required documentation. This was discussed with staff during supervision and advice was given on the importance of ensuring that care plans were accurately completed and remained up to date. Month end audits were completed and this enabled the manager to quickly assess whether any areas required action. These audits reviewed infection control, complaints / compliments, pressure sores and accidents / incidents / near misses. Any concerns were noted and these were submitted to the regional manager for review.

In addition to the audits completed by the service, stakeholder surveys were also carried out for people

using the service, relatives and staff. We saw that the results were largely positive, and where negative feedback had been received, the manager had investigated this and plans had been put in place to address the issues. We looked at the service user survey completed in January 2016. We saw that some people using the service felt that having more staff on shift would improve the service they received. The manager told us that they completed a review of the staffing levels, carried out a recruitment drive and as a result the number of staff on each shift increased from four to five.

We discussed the key challenges the manager felt the service faced. They recognised the care sector had changed and people moving into residential care had much higher levels of need. This meant that staff needed to have additional training to ensure they had the right skills to effectively support people. The manager told us they had started a dementia café that relatives of people using the service had been invited to. This provided an opportunity for people to receive information and advice on the different types of dementia and how the families and the home could best work together to provide the support that people needed. The manager hoped this would help relatives cope better with the distress caused when a person moved into a care setting, and forge positive relationships between the staff team and people's relatives.

The manager told us they were also working closely with the local hospital to try to keep people out of hospital during the end of their life (if this was their preferred choice). They were in the process of surveying staff to see what elements of the end of life process they were unfamiliar with and planned to provide training to address these concerns to prevent people from spending their final days in hospital.

The service was well organised and this enabled staff to respond to people's needs effectively. The service kept records on people that used the service, staff and the running of the business that were in line with the requirements of the regulations and we saw that they were appropriately maintained, up-to-date and securely held. This meant that people's personal and private information remained confidential.