Peter Coleman

Seahorses

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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 undertook an unannounced inspection of Seahorses on 19 October 2017.

Seahorses is registered to provide accommodation and personal care for up to 20 people. On the day of our inspection there were 15 people living at the home. People were living with various stages of dementia and associated conditions.

At our last inspection on 4 and 23 March 2016 we found breaches of Regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Records did not show the Mental Capacity Act (MCA) 2005 had been followed in relation to consent, the home was not always clean, risks were not always identified and appropriately managed, medicines were not always managed safely and audits were not always effective. In addition the environment and décor of the home did not always support people living with dementia.

At this inspection we found the home had made improvements to address the areas of concern and bring the service up to the required standards.

There was a registered manager in post. 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.

Staff understood the Mental Capacity Act (MCA) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected, this included people who were deprived of their liberty. Records relating to the MCA were accurate and up to date. People were offered choices and their decisions were respected.

The home was clean and free of malodours. Cleaning schedules were in place and staff followed schedules using personal protective equipment. New carpets and easy clean furniture had been installed and the bathrooms, toilets and laundry were clean and smelt fresh.

Where risks to people had been identified, risk assessments were in place and action had been taken to manage the risks. Staff were aware of people's needs and followed guidance to keep them safe.

People received their medicines as prescribed and systems were in place to safely store and manage medicines. Medicine records were accurate and up to date.

Records in relation to people who used the service were complete and accurate. The registered manager conducted regular audits to monitor the quality of service. Learning from these audits was used to make

improvements.

Whilst some improvements had been made the décor and environment did not always support people living with dementia. The registered manager was aware and understood the need to improve the environment. We have made a recommendation in relation to the dementia environment.

We were greeted warmly by staff at the service who seemed genuinely pleased to see us. The atmosphere was open and friendly.

People told us they were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

People were supported by staff that were extremely knowledgeable about people's needs and provided support with compassion and kindness. All staff had received dementia training. People received quality care that was personalised and met their needs.

There were sufficient staff to meet people's needs. Staff responded promptly where people required assistance. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

The service responded to people's changing needs. People and their families were involved in their care and how their care progressed and developed.

Staff spoke extremely positively about the support they received from the registered manager. Staff supervisions and meetings were scheduled as were annual appraisals. Staff told us the registered manager was very approachable and supportive and that there was a very good level of communication and trust within the service.

The service sought people's views and opinions. Relatives told us they were confident they would be listened to and action would be taken if they raised a concern.

People had sufficient to eat and drink. Where people required special diets, for example, pureed or fortified meals, these were provided by kitchen staff who clearly understood the dietary needs of the people they were catering for.

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

There were sufficient staff deployed to meet people's needs.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place to reduce the risks and keep people safe. People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported in an environment designed to be dementia friendly.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring

People benefitted from caring relationships with staff.

Staff were very kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people. Staff were motivated and committed to delivering personalised care.

People and their relatives knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make sure their needs could be met. Support needs were regularly reviewed.

Is the service well-led?

Good

The service was well led.

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

The registered manager led by example and empowered and motivated their staff. Staff's actions and attitudes mirrored this example.

The service shared learning and looked for continuous improvement.

Seahorses

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, see if improvements had been made and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 October 2017 and was unannounced. The inspection was carried out by an inspector.

The majority of people living at the home were living with dementia and could not speak to us. However, we spoke with two people, three relatives, two care staff, the cleaner, the chef and the registered manager. We also spoke with a visiting healthcare professional. We looked at five people's care records, four staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care. We observed people's care and used Short Observational Framework for Inspection (SOFI). SOFI provides a framework for directly observing and reporting on the quality of care experienced by people who cannot describe this themselves.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law. In addition we looked at reports of inspections conducted by the local authority commissioner of services.

Good

Is the service safe?

Our findings

At our last inspection in March 2016 we found areas of the home were not clean and infection control guidance was not always being followed. Not all risks were identified and managed appropriately and staff were not always provided with guidance to enable them to manage the risks. People's medicines were not always managed safely.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made. The home was clean, tidy and free from malodours. Bathrooms were clean and smelt fresh. Whilst old, bathrooms and associated equipment were clean, maintained and serviceable. Bathrooms were free from clutter and people's personal items such as razors or toiletries. The laundry was clean tidy and smelt fresh. Communal areas of the home were clean as were people's rooms and we saw cleaning staff following cleaning schedules covering all areas of the home. New carpets had been fitted and new 'easy clean' furniture installed in the dining room. Where people required hoisting we saw personal slings were held in the person's room preventing the risk of cross contamination. We observed a cleaner who followed safe operating practices and used personal protective equipment as they worked. The cleaner told us, "I get good support here, no shortage of gloves, aprons or equipment. We use colour coded mops and buckets for different areas of the home. I have a set of schedules and a daily cleaning book I work through. I've no problems as this system works really well".

Where risks were identified there were plans in place that guided staff how to support people to manage the risks. Risks identified included: pressure damage, choking, moving and handling, and nutrition. For example, one person was cared for in bed and at risk of developing pressure ulcers. Staff were guided to regularly monitor the person's skin and reposition the person 'every two hours'. Pressure relieving equipment was also put in place and was correctly set up for the person. Charts recorded that staff were repositioning this person in line with their care plan. This person did not have a pressure ulcer.

One person sometimes presented behaviours that may challenge others. The person's care plan did not identify any triggers to this behaviour as occurrences were random and unpredictable. The behaviours were not physical but vocal and repetitive. Staff were guided to allow the person to speak until they had finished and engage the person in conversation. During our visit we saw staff using this guidance which calmed the person.

Another person could mobilise independently. Staff were guided to hold the person's hand when they mobilised independently to keep them steady. However, this person's mobility could fluctuate. Staff monitored the person and when staff recognised the person was struggling two staff were required to support the person with standing and walking. We observed this person walking, holding the hand of a staff member in line with the guidance. Other measures were in place to protect people. All hot water taps in the home had been fitted with thermostats to ensure hot water was available at safe temperatures. This system was serviceable, monitored and maintained regularly.

Medicines were managed safely and people received the medicines as prescribed. Medicines were stored safely and securely. Systems were in place to ensure stocks of medicines were managed and were safe to administer. For example, medicines dispensed in liquid forms were marked with a date of opening to ensure they were disposed of when their shelf life expired. Records evidenced medicines were correctly disposed of by expired dates listed on the labels.

Medicine records detailed a list of the medicines prescribed and what condition the medicine was prescribed for. Medicine administration records (MAR) were completed fully and accurately. Staff administering medicines had signed the MAR to confirm people had taken their medicines.

Where people were prescribed 'as required' medicines there were protocols in place that detailed when the person may require the medicine, the dose and frequency of use. All protocols had been signed by the GP. Where people required homely medicines for conditions such as a headache or constipation, the GP had been consulted.

We observed a medicine round. Staff identified the person and explained what they were doing. They sought the person's consent before administering the medicine. When they were satisfied the person had taken their medicine they signed the MAR. However, we saw one staff member handling tablets without using gloves or a dispensing cup, prior to administering these tablets to a person. We challenged the staff member who said, "Oh my God you are right, I'm so sorry I just forgot". We raised this with the registered manager who said, "I know, [staff member] came straight to me and told me. I will deal with this through advice and guidance, definitely".

People told us they felt safe. One person said, "I do feel safe, nothing is wrong". Another said, "Oh I feel safe here. The staff are pretty good you know". One relative commented, "Safe? Absolutely. The staff here are angels. [Person] is well cared for".

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their manager or the senior person on duty. Staff were also aware they could report externally if needed. Comments included; "I'd raise any concerns with the manager and I can go to the local authority" and "I would speak to my manager and if needed call the safeguarding team". The service had systems in place to investigate concerns and report them to the appropriate authorities.

There were sufficient staff on duty to meet people's needs. The registered manager told us staffing levels were set by the "Needs of our residents". Staff were not rushed in their duties and had time to sit and chat with people. Where people's behaviour indicated the person needed help staff responded in a timely manner to prevent the person suffering anxiety. People were assisted promptly when they called for assistance. Staff rota's confirmed planned staffing levels were consistently maintained. One person told us, "If I call for assistance they come quickly". One relative said, "I have never seen a lack of staff so yes, they have enough".

Staff told us staffing levels were sufficient to meet people's needs. Comments included; "Yes we do have enough staff" and "I think there's enough staff, we work together so it all goes smoothly". All of the staff we saw at the home had been working there several years.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their

role. This allowed the registered manager to make safer recruitment decisions.

Accidents and incidents were recorded and investigated. These records were held in people's care plans. Where appropriate, action was taken to reduce the risk of reoccurrence of any accident or incident. For example, following an incident one person was referred to a community healthcare professional. The person's care was reviewed and changes were made to support the person effectively.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2016 we found concerns relating to involving people in decisions about their care which was not in line with the Mental Capacity Act (MCA) 2005. We were concerned people were not involved in their care in line with the Mental Capacity Act (MCA) 2015. We were also concerned that people were being restrained, through the locking of bathroom and bedroom doors, without proper consideration of the MCA. The Act 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.

This concern was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations
2014.

At this inspection we found improvements had been made. People's care plans included mental capacity assessments which identified the decisions people lacked capacity to make. Where people lacked capacity to make certain decisions their best interests had been considered and had involved family members and healthcare professionals. Care plans detailed how people should be supported in their best interests. For example, one person's care plan identified they lacked capacity to make decisions relating to their finances and decisions related to their care and welfare. This person had identified representatives who had legal authority to make decisions on this person's behalf and copies of the authority were available. For example, one person was assessed as not having capacity relating to a decision about where to live. The person's best interests had been considered and the decision involved healthcare professionals, social workers and the person's legal representative.

Staff were reminded to seek people's consent in care plans. For example, one person's care plan stated 'should [person] indicate or say no, return in ten minutes and try again'. We saw staff following this guidance with this person. Throughout our visit we saw staff seeking people's consent and respecting their decisions. For example, at the lunchtime meal people's preferences regarding food and drink were sought and respected.

The registered manager carried out assessments to determine if people were subject to any restrictions in relation to their care. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Where restrictions were in place the registered manager had made DoLS applications to the supervisory body. People's care plan detailed the restrictions in place and how people were supported to ensure any restrictions were the least restrictive. At the time of our inspection one person was subject to an authorised DoLS. Bathroom and toilet doors were unlocked and accessible to people. Bedroom doors were locked and people could access their room using their own key, or if they did not want a key, by a staff member. The person was able to leave their room without the use of a key. This meant people had free access to their own rooms with the

reassurance their rooms were secure. The registered manager said, "This prevents people going into other people's rooms and we do not consider this a form of restraint".

Staff had completed training in MCA and DoLS. Staff had a clear understanding of their responsibilities to support people in line with the principles of the Act. One member of staff told us, "I give options and choices. I explain things and give them time to decide. It is about individual decisions". Another staff member said, "I always seek consent. I never work without doing so". One person commented about consent. They said, "They (staff) always ask my permission before helping me".

People told us staff had the skills to support them effectively. One person said, "They (staff) know what they are doing". A relative said, "Yes they (staff) certainly have the knowledge and skills to care for [Person]".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they had received an induction and completed training when they started working at the service. Induction training included fire, moving and handling, dementia and infection control. Staff were positive about the training they received and were supported to attend regular updates to ensure their skills and knowledge were kept up to date. Staff comments included; "The training here is good" and "Very good training, and if I ask for further training I get it". Records confirmed staff received further training relating to people's needs or at the request of staff. For example, all staff had received dementia training and records confirmed regular refresher training was provided. Staff used this training effectively when supporting people. We saw one person was confused about their menu choice at lunchtime. The staff member crouched next to the person and slowly explained what the person had ordered as a meal. As the person remained unsure the staff member brought them the meal so they could see and consider their choice. The person saw the meal, understood and was happy. Throughout the staff member showed kindness, consideration and patience.

This training, along with staff's knowledge of people meant people received good quality care from a responsive staff group. However, the home environment was not always in line with best practice for people living with dementia. The lounge area was homely and contained furnishings, pictures and activity equipment that would stimulate a person. People's rooms were personalised. However, the corridors were not dementia friendly. Handrails, walls and doors were painted a uniform colour. This did not provide a contrast for people and would not support ease of navigation around the home. Some period pictures were hung on the walls and a large poster was displayed that depicted a shop front. No other stimulation for people was available in this area. We raised this with the registered manager who said, "I am aware we have an old, tired building but we are planning to redecorate in a dementia friendly way in the very near future".

We recommend the registered manager refers to guidance relating to the dementia environment.

Staff told us, and records confirmed they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. One member of staff told us, "I am supported 100%. I see my line manager all the time and can ask for or talk about anything". Another said, "I am well supported here, both work wise and personally".

People had access to food and drink to meet their needs. Where people had specific dietary requirements this was detailed in their care plan. People received food and drink in line with the guidance. For example, following and assessment by a speech and language therapist (SALT) one person required a 'pureed diet' due to the risk of choking. We saw this person being supported with a meal that was of the correct consistency. Menus were displayed and staff assisted people with their meal choices. Staff were also very

knowledgeable about people's food and drink preferences and could tell us what meals people preferred. The chef told us they were aware of those people with specific medical conditions such as diabetes or those losing or gaining weight. The chef said, "I am kept up to date with resident's needs, I'm updated daily in fact and I also check their care plans. We run menus on a four week cycle with choices at every meal. I make cakes for resident's birthdays and if families want to hold a tea party I cater for that as well".

We observed the midday meal experience. This was an enjoyable, social event where the majority of people attended. People sat where they wanted in either the dining room or lounge. Food was served hot from the kitchen and looked 'home cooked', wholesome and appetising. People were offered a choice of drinks throughout their meal. People were encouraged to eat and extra portions were available.

People told us they enjoyed the food. Comments included; "The food is not bad at all and they know what I like. I get enough to drink as well" and "I very much enjoy the food. It's good". One relative said, "[Person] thinks the food is good and that's all that matters".

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included the GP, community nurses and speech and language therapist (SALT). Visits by healthcare professionals, assessments and referrals were all recorded in people's care plans. We spoke with a visiting healthcare professional. They said, "It has really improved here. The residents are so well loved. I would have my grandmother here. I get good referrals and the staff follow guidance so I have no concerns, and I come here regularly so I should know. They take quick action, I am happy it is a good home".

Good

Is the service caring?

Our findings

People told us they enjoyed living at the home and benefitted from caring relationships with the staff. One person said, "Yes they (staff) are caring. They are very good for that here" and "Oh yes, they look after me". One relative said, "Absolutely, it is very caring here, more than I ever expected".

People were supported by a dedicated staff team who had genuine warmth and affection for people. Staff comments included: "I love the fact we make people smile. It's a very rewarding job" and "Supporting our family of residents is the best".

People were cared for by staff who were extremely knowledgeable about the care they required and the things that were important to them in their lives. All the staff we saw had worked at the home for several years and knew people very well. Staff spoke with people about their careers, families and where they had lived. During our visit we saw numerous positive interactions between people and staff. For example, one person living with dementia would talk repeatedly about their dogs. Staff were aware of the importance of dogs to this person and patiently and repeatedly conversed with the person who smiled as they spoke about their experiences. This interaction clearly calmed the person and enhanced their well-being.

Another person was supported to the dining room. Staff asked if they wanted to sit in their "usual seat". The person nodded and sat down. Staff then engaged the person in conversation about their meal choice, offered drinks and spoke about the garden. From the conversation it was clear staff knew the person's interests. This engaged the person who was enthusiastic about the conversation.

People's independence was promoted. For example, during the lunchtime meal we saw people being encouraged to eat independently. Staff only intervened when the person needed or requested support. We also saw one person walk independently into the dining room. They were however, a little unsteady on their feet. A staff member walked with the person, offering encouragement but ready to support the person if necessary. This promoted the person's independence to walk independently.

We spoke with people about independence. When asked if their independence was promoted one person said, "Pretty much, they encourage me and let me do what I can". One relative commented, "They try to promote his independence. I think they cope with [Person] fantastically".

People and relatives were involved in care provision. Throughout our inspection we saw staff involving people in their care, offering choices and explaining what was happening. Staff gave people time to absorb information and supported them to make decisions about their care. For example, we saw staff explaining to one person why it was important to eat their meal at lunchtime and offered alternatives. The person's decision was respected. One relative said, "They (staff) answer every question I ask with a full explanation. I am fully involved".

People's dignity and privacy were respected. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. We

saw people were treated with dignity and respect throughout our inspection. People were addressed by their preferred name and staff knocked on people's doors before entering. One relative commented on how staff spoke with respect to a person. They said, "Respect? Most definitely".

Care plans guided staff to treat people in a respectful and dignified way. For example, one person was approaching the end of their life and slept most of the day. Staff were reminded to 'talk to [Person], even if asleep when providing support', to promote their dignity.

Where people had expressed a preference their wishes relating to 'end of life' care were recorded and respected. Advanced care plans recorded people's preferences and wishes. For example, whether people wished to be buried or cremated, funeral and family arrangements and their choice of music for funerals.

People's personal and medical information was protected. The provider's policy and procedures on confidentiality were available to people, relatives and staff and gave details of when and how information would be shared with other professional bodies once the person's consent had been obtained. Care plans and other personal records were stored securely. Staff were discrete when speaking to people about their care needs and did not speak about people's needs in front of other people or relatives.

People's cultural needs were identified and people were supported to meet those needs. For example, one person was religious and records confirmed this person was supported to continue their faith. We spoke with the registered manager about diversity. They said, "Both [Provider] and I have diverse backgrounds so we understand the need to treat people as individuals, which is exactly what we do". The provider's diversity policy supported this statement.

Good

Is the service responsive?

Our findings

At our last inspection in March 2016 we found care plans did not always demonstrate people's needs and lacked detail relating to those needs and how staff should support people to meet their needs. We also found staff did not always respond to people's needs.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made. People's needs were assessed prior to admission to the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person liked walking and music. Another person 'loves all food especially sweet things'. The chef was aware of this person's food preferences and we saw this person had two sweet puddings at the lunchtime meal.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person's care plan detailed how the person could have difficulty verbalising. The care plan stated, '[Person] can give verbal consent but sometimes gestures with a nod of the head'. Staff we spoke with were aware of this person's methods of communication. One staff member commented about how they personalised people's care. They said, "It's really all about choices and giving them (people) the care they want, the way they want it. That's what we do here".

Another person had stated their goal was 'to be clean and fresh at all times'. The person's preferred washing method was detailed and included using 'soap and a flannel'. Staff were provided with detailed guidance on how to support the person which also reminded them to use personal protective equipment (PPE) where appropriate and to offer the person a choice of clothing. We saw this person during our inspection and they were clean, tidy and well presented at all times.

People were able to access the information they required. For example, menu choices were provided and staff would sit with people and describe the options available. Staff would then show the person the plated meals for people to choose. We saw staff walking with people to the lounge area showing them an activity in progress and ask the person whether they wished to join in. Where people had difficulty hearing staff were guided to communicate in the person's preferred method. For example, one person's care plan guided staff to 'make eye contact and speak clearly and slowly'. This guidance added the person required time to take in the information. We saw staff speaking to this person following the guidance.

Care plans and risk assessments were reviewed to reflect people's changing needs. Where people's needs changed the service sought appropriate specialist advice. For example, one person required medicine for their condition. When their condition changed the service referred the person to the GP who prescribed a new medicine. Records confirmed the new medicine was being administered. Another person's condition

had progressed and they became active during the night. This placed the person at risk of falling down the stairs if they left their room in the night. The service responded by placing a sensor mat outside the person's room at night. This alerted staff if the person left their room yet allowed them to be active in their room where they were safe.

People were offered a range of activities including games, sing a longs, crosswords, pampering sessions and walks. Weekly church services were held which people were supported to attend. The home had a large garden with level, wheelchair friendly foot paths, borders and garden furniture for people to access. During the inspection we saw people engaging in a ball throwing activity. Staff encouraged people and praised their efforts. It was a lively, fun activity that people clearly enjoyed. One person we spoke with told us, "There seems to be a fair bit going on though I pick and choose what I take part in. They always offer which is nice". Another person said, "I've enough to do here".

The services complaints policy was displayed in the home and was given to people and their families when they joined the service. The policy also contained details of how to complain and contact details for the Local Government Ombudsman (LGO) and the Care Quality Commission (CQC). Records showed the service had not received any complaints. The registered manager told us, "We tend to deal with any issues long before a formal complaint needs to be raised". There was a system in place to record and investigate a complaint should one be received. One person spoke about complaints. They said, "Oh I would tell them if I had a complaint, no problem. I do think they would act if I raised a complaint". A relative said, "If I had a concern I'd speak to the manager. In fact I have done with a minor issue. That was dealt with and I'm confident they would do something about any issue I brought to them".

The provider sought people's opinions through regular surveys. Records we saw demonstrated people were very positive about the service. The latest survey results for June 2017 did not contain any issues or required actions and the registered manager told us, "I analyse the results to look for patterns they may need dealing with".

Good

Is the service well-led?

Our findings

At our last inspection in March 2016 we found the auditing system to monitor the quality of the service was not always effective. Monitoring systems did not identify our concerns. Management systems relating to cleaning did not cover communal areas and the training file lacked organisation and did not demonstrate the training staff had been completed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made. Regular audits were conducted that included infection control, medicines and records. Action plans were created from audits to improve the service. For example, one audit identified the need to replace the first aid boxes. A target date was set and the action was signed of as completed within the action date. We saw new first aid boxes were in place. Another audit identified a hand written MAR had been received from the pharmacy. Staff had then contacted the pharmacy and a printed MAR had been provided. Training records had been reviewed and were up to date and new cleaning schedules for the home, including communal areas had been implemented. The registered manager showed us a new monitoring system they had recently invested in. Records were in the process of being updated for the new system which included an online monitoring process that analysed audits, records and accidents and incidents. The registered manager said, "The new system will provide an overview and allow us to look for patterns and trends so much easier. It will be working very soon". The registered manager was aware of our concerns relating to the décor of the home and understood the need to improve the environment in relation to people living with dementia..

People clearly knew the registered manager who was visible around the home throughout our visit. We saw them engaging with people who greeted them warmly with genuine affection. The registered manager knew people and called them by their preferred name. People and their relatives told us the service was well managed. One person said, "This place is clean and seems very well run. I know the manager and she is alright". Another person said, "[Registered manager] is nice". A relative spoke with us about the registered manager. They said, "She is excellent, very business-like but also very friendly. This home is homely, welcoming and it is very good".

Staff spoke positively about the registered manager. Staffs comments included; "[Registered manager] is great, approachable and supportive", "The manager is lovely, you can talk to her about anything". She is brilliant" and "I am really well supported by [Registered manager]". A visiting healthcare professional said, "I have a really good relationship with [Registered manager]. Communication is very good between us which is so reassuring".

The registered manager led by example. Throughout the inspection the registered manager and provider were available to people, visitors and staff. It was clear the management team led by example and created an open, caring culture that put people at the centre of all they did. The registered manager knew people, staff and visitors well. They took time to stop and speak with everyone, showing empathy and support for

all. We saw staff mirrored this approach and maintained this positive culture that was embedded into the caring ethos of the home.

Visitors were clearly welcome in the home and we saw many interactions between people and visitors who were chatting with others living in the service. There was a family atmosphere where everyone was valued and included.

Staff told us learning was shared in the home and communication was good. One staff member said, "We have meetings to discuss residents needs and of course, we have handovers every shift change. We are always chatting". Another staff member said, "We have handover and staff meetings where we shared knowledge and learning. I think I am kept up to date with things". We saw staff meeting minutes where staff discussed the changes to a person's condition. Staff suggested strategies to manage these changes and discussed how to implement them.

There was a whistle blowing policy in place that was available to staff around the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.