Four Seasons 2000 Limited

Hesslewood House

Inspection report

Hesslewood House
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Date of inspection visit: 9 & 16 September 2015
Date of publication: 31/12/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Hesslewood House is registered to provide accommodation and nursing or personal care for up to 86 people. The service has three units for young adults and older people, some of whom may have a physical disability, learning disability or dementia related condition. The three units are Oak tree, Cherry tree and Beech tree. On the first day of this inspection there was 65 people using the service.

The inspection was unannounced and took place over two days on 9 and 16 September 2015. At the previous inspection on 5 September 2013 the regulations we assessed were all being complied with.

The registered provider is required to have a registered manager in post and on the day of the inspection 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

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe living at the service. We found that staff had a good knowledge of how to keep people safe from harm and that there were enough staff to meet people's needs. Staff had been employed following robust recruitment and selection processes. Medication was suitably managed.

People were supported to make their own decisions and when they were not able to do so, decisions were made in their best interests. If it was considered that people were being deprived of their liberty, the correct documentation was in place to confirm this had been authorised.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community.

People's nutritional needs had been assessed and they were happy with the meals provided at the service. We saw there was a choice available at each mealtime, and that people had been consulted about the choices available on the service's menu.

People told us that staff were caring and this was supported by the visitors who we spoke with.

The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service is safe.

People that used the service were protected from the risks of harm or abuse because the registered provider had ensured staff were appropriately trained in safeguarding adults from abuse and the registered provider had systems in place to ensure safeguarding referrals were made to the appropriate department.

People were safe because staffing was in sufficient numbers to meet people's needs, staff were recruited safely and medication management was suitably handled.

Good

Is the service effective?
The service was effective.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and people were supported to make decisions about their care.

Staff told us that they completed induction and on-going training that equipped them with the skills they needed to carry out their role.

People's nutritional needs were assessed and met, and people told us they were happy with the meals provided by the home.

Good

Is the service caring?
The service was caring.

People who lived at the service told us they felt staff cared about them and we observed positive interactions between people who lived at the service and staff on the days of the inspection.

People told us that they were treated with dignity and respect and this was observed throughout our visit.

People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

Good

Is the service responsive?
The service was responsive to people's needs.

People's care plans recorded information about their previous lifestyle. Their preferences and wishes for care were recorded and these were known by staff.

People were able to take part in their chosen activities and their visitors were made welcome.

People were able to make suggestions and raise concerns or complaints about the service they received.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

Staff were supported by the registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with their registered manager.

There were sufficient opportunities for people who lived at the service, relatives and staff to express their views about the quality of the service provided.

The registered manager regularly checked the quality of the service provided.

Hesslewood House

Detailed findings

Background to this inspection

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

This inspection took place over two days on 9 and 16 September 2015 and was unannounced. The inspection team on the 9 September 2015 consisted of two adult social care (ASC) inspectors from the Care Quality Commission (CQC) and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to older people living with dementia and nursing care. On the second day of this inspection on 16 September 2015 the inspection was carried out by one ASC inspector.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the East Riding of Yorkshire Council (ERYC) Contracts and Monitoring Department and Safeguarding Team. We did not ask the registered provider to submit a provider information return (PIR) prior to the inspection. The PIR 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.

During the inspection we spoke with the registered manager, deputy manager and regional manager. We also spoke with five staff, six visitors and twenty people who used the service. We spent time looking at records which included the care records for four people who used the service, the recruitment, induction, training and supervision records for four members of staff and records relating to the management of the service. We spent time observing the interaction between people and staff in the three units communal areas and during mealtimes.

Good

Is the service safe?

Our findings

People that used the service with whom we spoke consistently told us they felt safe. Comments included, "You know there is a special lock on the door and it feels safe like that," "I'm happy living here" and "I know the call bell is there if I need it."

The service had policies and procedures in place to guide staff in safeguarding vulnerable people from abuse. We found that the service had information about the ERYC safeguarding risk management tool. The registered manager kept a safeguarding log which described the incident or allegation, alerts made and the outcome. We saw from information we held that there had been safeguarding referrals made in the last 12 months and outcome reports at the service showed they had taken appropriate action in response to these. CQC had been notified of the alerts. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We spoke with four staff about their understanding of safeguarding. Staff were able to clearly describe how they would escalate concerns both internally or externally should they identify possible abuse. They told us, "I would tell a senior member of staff and we have a whistle blowing policy," "I would go to the senior, manager or CQC with the concerns I had" and "I would intervene and make sure the person was safe then raise with my manager or the nurse in charge." Staff told us they had completed training in safeguarding adults. We were provided with the service training plan after the inspection. We saw that 92% of staff had completed safeguarding vulnerable adults training.

The registered manager provided us with the service staff dependency tool 'Chess' (care home equation for safe staffing). This took into account the assessed needs for each person who used the service. For example, continence, hygiene, nutrition and mobility. We saw this was completed on a monthly basis by the registered manager. The level of support required was given a level of risk from low to high which equated to the total hours required. This meant staffing levels in the service could be adjusted as people's needs changed to ensure there were sufficient staff at all times.

We looked at the duty rota in Beech tree for the four weeks leading up to our inspection. These indicated which staff were on duty and in what capacity and the staff we met on the inspection matched those on the duty rota. The rotas showed us there were sufficient staff on duty during the day and at night, with sufficient skill mix to meet people's assessed needs. The staff team consisted of nurses, care staff, ancillary workers and activity coordinator.

We asked staff if they felt there were enough on duty we received a mixed response. Some felt there were enough on duty but others said there were times they were short staffed. They told us, "Sometimes there isn't enough staff, today there is five which we can't believe as there is usually four with two RGNs" and "Yes, occasionally if people call in sick it has to be covered but overall yes." We noted ten call bells during the inspection. Some were responded to more promptly than others, but all were responded to within a reasonable time.

We looked at the recruitment files of four members of staff. Application forms were completed, interviews were carried out and staff were provided with job descriptions. This meant they were aware of what was expected of them. We saw references were obtained and checks made with the disclosure and barring service (DBS). The DBS check information, once received, records if potential employees have a criminal conviction which tells providers they are unsuitable to work with vulnerable people and helps employers make safer recruitment decisions. This meant that people who used the service were not exposed to staff who were unsuitable to work with vulnerable adults.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, use of bed rails and choking ; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. We saw one area of concern in a person's nutritional needs care plan. This did not reflect the change in risk levels in the persons risk assessment in relation to choking. This meant that any changes may not be identified and addressed at an early opportunity. We saw that risk assessments were reviewed but care plans did not always reflect the change in risk levels that staff had identified. We discussed our findings with the registered manager who agreed to look into this.

The registered manager monitored accidents within the service to ensure people were kept safe and any health and

Good

Is the service safe?

safety risks were identified and actioned as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the registered manager.

Clear records were maintained of checks carried out on bed rails, mattresses, window restrictors, wheelchairs and tall furniture. We saw records that showed service contract agreements were in place, which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment included alarm systems for fire safety and the nurse call bell, lifts, portable electrical items, water, gas and electrical installation systems. These environmental checks helped to ensure the safety of people who used the service.

We were provided with the service business continuity plan. The plan identified the arrangements to be made if an emergency situation arose to ensure access to other health or social care services in a time of crisis. This would ensure people were kept safe, warm and had their care, treatment and support needs met. We saw people who used the service had a personal evacuation plan in place and each person's bedroom door had a colour coded sticker in line with the service fire procedures to indicate the risk level for fire evacuation.

We assessed the medication management systems used by the service in Beech tree and Cherry tree units. We saw the service had a medication policy that was reviewed in 2015. The policy included the arrangements for obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

The service used a monitored dosage system. This is a system where a measured amount of medication is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. This 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 saw that one person was given medication covertly. Covert administration of medicines is only used when medication needs to be given in a disguised format, for example in food or a drink, without the knowledge of the individual and only when the decision to administer medication in this manner has been discussed and agreed with those involved in their care and has been deemed in their best interests. The decision record was clearly recorded and signed by those who had been involved in the process.

Medicine administration record (MAR) charts contained clear details of when and how medicines were to be given. We checked a selection of medication administration records (MARs). We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them and administered. We saw the medication fridge temperature was taken and recorded each day; the temperatures were consistently within recommended parameters. We saw evidence that one person had been administered a controlled drug and this had not been signed or deducted from the stock total in the controlled drugs register. We checked the persons MAR and the controlled drug. Both had been signed as administered. This was discussed with the registered manager and the controlled drugs book and stock total were completed whilst we were at the service.

We found the service returned or destroyed medicines that were no longer required. We saw on Beech tree there was a 'returns book' that recorded the date, person's name, name of the medicine, quantity, reason for return and signature of person completing. We saw the pharmacy that collected the medicines did not sign the services 'returns book'. However, we saw a pharmacy collection sheet on both units that had been signed by the person collecting the medicines. We saw on Cherry tree that medicines for return were stored in the medication room to be collected by the pharmacy. We were told unused medicines were put into 'yellow destruction boxes' on the premises.

Good

Is the service effective?

Our findings

In discussions with us, staff were clear about how they gained consent prior to delivering care and treatment. One staff member told us "I always give people a selection of choices, sometimes I will show pictures or point things out." Another told us "This morning I went in to see (X) and asked if they wanted to get up. I asked if they wanted the bedroom light on first. (X) told me they wanted to stay in bed for another half an hour which I respected. Later when (X) decided to get up I helped them choose between clothes to wear such as nightwear, jumper or another top. At lunchtime I asked if (X) wanted to get out of bed for lunch and this was declined."

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

Discussion with the registered manager showed they had a clear understanding of the principles of the MCA and DoLS, and we saw that if it was considered that people were being deprived of their liberty, the correct authorisations had been applied for. One person's care plan recorded that a DoLS application had been submitted to the local authority for consideration and had been authorised. This was due for renewal in August 2016.

Some people who used the service required more support from family members to make life changing decisions. We saw in care plans the registered manager had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions. One person's care plan had a 'Do Not Attempt Resuscitation' (DNAR) form in place that clearly recorded their family member and health consultant had been involved in the decision making. We saw that the service held best interest meetings with people and their representatives when necessary. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf.

When we spoke with staff they demonstrated an understanding of MCA and spoke about the importance of obtaining people's consent in all things. They told us, "It's about the person's ability to make decisions for themselves and if they can't it would be done in their best interest" and "MCA is for people who cannot decide for themselves."

We looked at induction records for five members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who lived at the service. Of the five we looked at only one had a completed induction on file. We spoke with four staff who confirmed they completed an initial induction which orientated them to the service and covered information such as employment issues, policies and procedures and layout of the building. They told us, "My induction covered moving and handling, safeguarding and policies and procedures," and "I had fire training, moving and handling and health and safety training. My induction was good."

People who used the service and visitors told us they felt the staff were sufficiently skilled and experienced to care and support them and their loved ones. We observed staff helping one person to sit up using a hoist so they could be comfortable eating lunch. Every step of the process was explained to the person and they were kept involved throughout.

We looked at the service training plan which showed us completed percentages of staff training which included, fire safety (95%), infection control (91%), moving and handling practical (100%), care of medicines (100%), basic life support (72%), food safety level 2 (75%) and control of substances hazardous to health (COSHH 88%). This meant the staff were competent and skilled in providing the support and care people that used the service required.

We asked staff if they had regular supervisions with their line manager. We received a mixed response. They told us, "I'm supervised every two months by the management team, they have been brilliant" and "Supervisions aren't that regular." We looked at the supervision plans for all three units at the service for 2015. The plans had colour coded keys for appraisals, formal supervision, clinical supervision and group meetings. We saw Beech tree had 15 staff with an average of four supervisions. Cherry tree had 13 staff with an average of three supervisions and Oak tree had 17 staff with an average of two supervisions.

There was a record in people's care plans of any contact people had with health care professionals, for example,

Good

Is the service effective?

their GP, district nurse and the emergency services; this included the date, the reason for the contact and the outcome, plus a record of any advice given. We noted that advice received from health care professionals had been incorporated into care plans. Details of hospital appointments and the outcome of these were also recorded. We saw that people had information in care plans about their health care needs. This meant that staff had easy access to information about people's health care needs.

People had information in place that was ready for them to take to hospital appointments or admissions when they were unable to verbally communicate their needs to hospital staff. This meant that hospital staff would have access to information about the person's individual care and support needs.

Nutritional assessments had been carried out and we saw these included specific information about a person's nutritional and hydration needs. We saw that a number of people had fluid monitoring charts, these were in place to record how much fluid people had been given. They were used where people had been assessed as 'at risk of dehydration'. However we found one person's dietary and fluid intake chart indicated an 'adequate' amount of fluid was required. There was no clear information as to what 'adequate' meant in amounts. This meant that they may be at an increased risk of dehydration. Another person's nutritional needs were assessed as 'low' risk. However the person's food and fluid intake was recorded. We discussed this with the registered manager who agreed to look into this. We saw evidence in care plans that referrals had been made to nutrition and dietetics services appropriately.

We observed that people who lived at the home were provided with hot and cold drinks throughout the day. We saw the units had 'Dehydration stations' which were cold drinks machines that held various different flavours of juices. Staff we spoke with told us people that used the service chose which flavour they would like for the day. During the inspection we observed drinks being offered to people who could not help themselves.

We saw the service had a four week menu that reflected a variety of balanced and nutritious foods on offer, to suit people's tastes and preferences. We asked people who used the service what they thought of the meals. People told us, "Food is very good here" and "I like my food, I think it is meatballs today." Visitors we spoke with told us, " The residents are well fed and they feed me too" and " I come to help feed (X) as there is no real conversation anymore. By helping to feed (X) I feel like we are communicating."

Observation of the lunch time meal showed that the food was presented well. We saw in Oak tree that tables were laid with cream placemats, white crockery and appropriate utensils. Everyone was provided with a cold drink of orange or blackcurrant. We saw that people were shown the meals available and asked what they would like to eat. For example, one person was shown soup or gammon and vegetables. They refused both and said they would like a bowl of 'crunchy nut cornflakes'. Staff respected the person's choice and provided a bowl of 'crunchy nut cornflakes'. We asked people if the food was hot and they consistently told us, "Yes." The care staff chatted to people so there was a relaxed and enjoyable atmosphere in the dining room.

We observed in Cherry tree unit people were offered drinks such as varieties of juice and tea. Some people had their meals in their rooms and staff offered one to one support with this. We observed staff asking people if they needed support to eat their meals or if they wanted to be independent. Menus were on the tables and four staff supported people in the dining area. Two people had visits from relatives who supported them to eat their lunch, staff told us this was a regular occurrence for people. There was a pleasant atmosphere and people were able to eat at their own pace. This meant that people's nutrition and hydration needs were being met.

We saw that the environment within the service was comfortable, clean and homely. We saw that the main areas of the service were easily visible so that people who preferred to walk around could be seen and assisted if necessary. Bedroom doors had photographs on the outside and each door was numbered and a different colour. 66 of the 67 rooms at the service had en-suite facilities. All areas we looked at were well maintained and decorated.

Good

Is the service caring?

Our findings

During this inspection we observed that staff had a caring and considerate manner with people who lived at the home and that they knew people's needs well. We observed that there were good interactions between the staff and people, with friendly and supportive care practices being used to assist people in their daily lives. People who spoke with us said, "No place like home, but I am well cared for here," "They look after me a lot," "Staff are good at listening" and "Carers all work as a team, they are a good lot."

We saw that visitors came to the service throughout the day and that they were made welcome by staff. It was apparent that these were regular visitors who had a good relationship with the staff and the registered manager. They chatted to other people who lived at the service as well as their relative or friend. Visitors told us "The staff are very compassionate," "I come regularly and I cannot fault the place" and "(X) face lights up when staff come on and I know they are happy."

Staff told us that they read people's care plans and that these included information that helped them to get to know the person their likes and dislikes. Staff told us "I sit with people and talk about what they like. One person can become upset and vocal. I know they love Blackpool so I talk to them about that and it seems to help them relax," and "I sit down and speak with people about their likes, dislikes, preferences and any concerns they have."

When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. For example, we saw in one person's care plan there had been a physical change. The GP had been consulted and the person's relative had been informed. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.

In discussions, staff had a good understanding of how to promote privacy and dignity. They told us, "I ask if people feel comfortable and if they do not want a male carer I will get a female carer to support them" and "Making sure curtains and doors are closed. If supporting with personal care use towels to protect dignity. Nobody is the same, everyone has little things they like and don't like." We observed staff knocking on people's doors before entering. One person told us, "They (staff) always knock on my door and ask if they can come in."

On the day of the inspection we saw that staff encouraged and supported people to do things for themselves when they had the ability to do so. We observed one person supported to move from a wheelchair to a comfortable chair in the lounge area. The person was encouraged to do as much as possible for themselves when moving by the supporting staff. The person's privacy and dignity was upheld throughout with use of a blanket over their knees and staff involved the person throughout by talking through everything they did.

We observed a 'Dignity tree' in the service entrance. The tree had quotations of what people thought dignity was written on attached leaves. These had been completed by staff and visitors. We saw 'Dignity for everyone' please knock and wait signs hanging on people's bedroom doors when staff were in attendance providing personal care to people.

We found that people who used the service were well presented and dressed individually. People were wearing long sleeves to aid warmth and the areas of the service we observed were of a comfortable temperature.

There were systems in place to ensure information was shared with people, including meetings with people who used the service and their relatives. We asked people if they were kept informed about what was happening in the service. One person said, "The staff are very good at keeping me informed."

Good

Is the service responsive?

Our findings

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Each person living at the service had their own care file, which contained a number of care plans. We looked in detail at four of these files. The care files we looked at had been signed by the person using the service or their relatives to say it had been discussed with them.

We saw in care plans that people's needs had been assessed when they were first admitted to the service. Assessments had been undertaken on nutrition, tissue viability and mobility so that a person's level of dependency could be identified. This information had been used to develop care plans that reflected people's individual abilities and needs. Staff recorded a life history of the people using the service with information about the person's important memories and relationships. Care plans were personalised and recorded what was important to the person concerned and how to support them. Care plans were reviewed each month; this meant that people's care needs were continually updated to ensure they received appropriate care.

We saw that care plans included information about people's individual ways of communicating and how staff would be able to understand the person's needs when they were not able to verbalise them. One person's care plan told us, "I communicate with thumbs up / down but require patience from staff." We were able to verify this when talking to staff. They told us, "We use thumbs up / down and speech cards for yes and no for one person." Another person's care plan told us, "I am rather deaf and appreciate people speaking loudly and slowly."

We saw that formal reviews of care plans were carried out by the local authority. When more formal reviews were held, people who lived at the service and their relatives were invited to attend these meetings to discuss their care and support needs. This meant that staff had up to date information to follow about the people who they were supporting.

However, in one person's care plan we saw daily notes were not completed consistently. Some days had two entries and some only one recorded entry. We saw in another person's care plan that body maps indicated various bruises on the person. However, there were no dates as to when these bruises had occurred. We discussed this with the registered manager who told us the person was at high risk of falls and a referral had been made through the GP to the falls team. The person had been supported to move to another room that was larger to reduce the risk off falls and had a buzzer mat in place to alert staff when the person is moving around.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide personalised care to each individual. Staff told us, "(X) needs support to eat and drink, uses the hoist for moving around as is unable to weight bear" and "(X) only drank very small amounts when they first came to us. (X) is now eating well and has a straw for their drinks and can now take sips on their own." We were able to verify this in people's care plans.

Staff told us they talked about people at handover meetings to ensure they had up to date information. They said, "When a new person is due to come to the service the unit manager will talk to us about the person in detail during a handover."

We saw evidence of activities on offer in the form of an activity programme for September 2015.

During this inspection we observed some people participating in social activities. A visitor told us, "I can join in the activities if I want to, it depends on what they are doing." We saw people taking part in a game of skittles during the morning and the service held a 'Body Shop' party in the afternoon. We observed people were informed by staff on other units of the days activities offered. The activity co-ordinator shared their time between the three units on the day of the inspection.

Each person's care plan had an 'activities lifestyle plan' section. We saw one person's plan indicated the person's relative had requested they be encouraged to take part in some activities. We saw evidence that the person had joined in with music, singing and enjoyed watching other people dancing. A visitor told us the activity co-ordinator had encouraged their relative to make them a valentines card. The visitor told us this had made their day as they would have never expected this to happen. They told us they appreciated that the staff had encouraged and persuaded the person to do this. Another visitor told us

Good

Is the service responsive?

they had seen staff sat outside in the warmer weather chatting and reading books with the people living at the service and providing people with ice-cream and milkshakes. They told us, “It was like being at the seaside.” We observed an outside sensory area of sand, shells and buckets/spades. This depicted a seaside scene.

We asked staff what activities are offered at the service. They told us, “Singers come once a month and the zoo lab visits the service with animals. People do floor games, play dominoes, do painting and bowling. There have been some day trips to Blackpool.”

The service had a complaints policy and procedure on display in the entrance hall of the service. Checks of the complaints log showed all verbal or written complaints were summarised every month. Two complaints had been received and dealt with by the registered manager in 2015. The issues were well documented and good records were kept of all the actions taken to resolve the complaints. During this inspection a visitor told us of various concerns they currently had with the service. They told us this had been discussed with the registered manager and things had improved. However they were still not happy. We discussed this with the registered manager at the end of the inspection. They assured us this would be dealt with and the registered manager provided us with an outcome to this complaint.

Good

Is the service well-led?

Our findings

There was a registered manager in post on the day of this inspection. They had registered with CQC in November 2011. The registered manager was on leave on the second day of the inspection and we were assisted by the deputy manager, who had various responsibilities within the service and was able to assist with the inspection and locate documents that we required promptly. Overall, we found that records were well kept, easily accessible and stored securely.

The registered manager told us she had an open door policy and that people could speak to her at anytime. We observed the registered manager and deputy manager interacted well with people that used the service and people responded well to them. We were told that people who used the service were encouraged to be involved in recruiting new staff to the service. We were able to confirm this when speaking to one person. They told us, "I enjoy talking to the staff." We observed notices around the service in large print telling people the registered manager was available every Wednesday between 12 and 3pm for people that used the service and visitors to come and have a chat.

Staff described the management team as "supportive." They told us, "Absolutely I feel supported. Everyone gets on," "Yes I do, the team is fantastic," and "I have gone to them with personal things and they have supported me." We saw staff had supervision meetings with their manager and these meetings were used to discuss staff's performance and training needs.

Feedback from people who used the service, visitors and staff was obtained through the use of satisfaction questionnaires, meetings and one to one sessions. The service had introduced a 'Quality of life programme' in March 2015. This included a variety of questions for people that used the service, visitors, professionals and staff. We saw two ipads in the entrance area of the service. These were for people who used the service, staff and visitors to leave feedback. We were told this system had replaced the annual satisfaction surveys. The system alerted the registered manager when feedback was submitted and allowed for a call back to be requested by the person leaving the feedback. This information was analysed by the registered manager on a monthly basis and where necessary action was taken to make changes or improvements to the service. For example, we saw feedback from a visitor who had concerns. We were able to evidence records of a meeting with the visitor, registered manager and regional manager and contact with the person's social work professional to discuss the concerns. We saw a recorded list of all actions taken. We saw actions taken from the feedback displayed on a notice board entitled 'You said, we did'.

The service held staff meetings so that people could talk about any work issues and there were up to date policies and procedures regarding work practices that staff could easily access. We saw the minutes of the last recorded staff meeting in April 2015. Discussions were held about compliments received, medication practices, pressure damage, personal care and training needs. We saw the feedback left on the ipad system relating to the staff was very good. We were told there had been more recent meetings. However the minutes had not yet been written. We asked staff if they had regular meetings. They told us, "Yes people from all departments go so we all give our opinions," "We do, yes. The registered manager attends," and "Yes we have them once or twice a month."

Staff said overall there was a positive culture. When we asked about the culture, morale and openness of the service we received mixed responses. Staff told us, "I think it's ok but sometimes short staffing can get 'niggly' and I feel the nurses could help a little bit more such as supporting people to eat, getting up and going to bed," "Staff are fantastic, not one bad egg. The manager is good and there is a good rapport," and "I personally think it's good. Everyone is easy to get along with." We asked if staff suggested new ways of working and if the service was open to this. A staff member told us, "Yes, I suggested the day staff do not put the laundry away. I spoke to the team leader and they have listened to my views," and "The ipad gives us a voice, it allowed me to raise my concerns. The registered manager responded and we met to discuss them."

We saw minutes of the residents meetings held in April and June 2015. We noted they were asked if they had any concerns, comments or suggestions. No-one had any concerns but suggestions were made about changes to the menu and about activities. We saw a copy of the notice advertising the meeting in June 2015. There was a

Good

Is the service well-led?

newsletter for the service that included 92.8% of very good feedback from people that used the service and 'Fun day' information from the best dressed wheelchair and frame competition.

Quality audits were undertaken to check that the systems in place at the home were being followed by staff. The registered manager carried out audits of the systems and practice to assess the quality of the service. We saw audits were completed monthly on medication, bed rails and mattresses. Each unit at the service also completed weekly medication audits. We noted that the weekly medication audit had no area to record any actions needed. We saw that the audits highlighted any shortfalls in the service. For example we saw 'Encouraging mealtimes checks' completed in March 2015. This highlighted more linen napkins were needed. However, there was no record of when this had been actioned. It would be good practice to record when actions had been completed so there was evidence that any identified improvements had been noted and acted on.

We saw that accidents, falls and pressure ulcers were recorded and analysed by the registered manager monthly. We also saw that internal audits on infection control and care plans were also completed. This was so any patterns or areas requiring improvement could be identified.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the service told us they had an awareness of all the new notifications and had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.