Staywood Limited

Holly Tree Lodge 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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Holly Tree Lodge Care Home on 12 December 2016. This was an unannounced inspection. The service provides care and support for up to 40 people. When we undertook our inspection there were 40 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses, mental health needs or because they were experiencing difficulties coping with everyday tasks, with some having memory loss.

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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there was no one subject to such an authorisation.

We found that people's health care needs were assessed and care was planned and delivered in a consistent way through the use of their care plans. People were involved in the planning of their care. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans were put in place to minimise risk in order to keep people safe. We found that the care plans and risk assessments fully reflected the needs of people and what action staff should take to prevent a person from being at risk of harm.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period. The home was divided into two units and a core staff team worked in each unit, with some staff working across units depending on people's needs.

People were treated with kindness and respect. Staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

People had a choice of meals, snacks and drinks. Meals could be taken in dining rooms, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. There were menus on display so people could remind themselves of the choices they had made.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. On-going training was available for all staff. Professionally trained nurses were supported to maintain their registration with the Nursing and Midwifery Council.

People had been consulted about the development of the home and quality checks had been completed to ensure the home could meet people's requirements. There was an analysis of quality checks and any lessons to be learnt were passed on to staff through meetings and supervision sessions.

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.

Checks were made to ensure the home was a safe place to live.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse. Risk assessment were kept up to date and staff ensured people were protected from harm.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing. Menus were on display, so people could be reminded of their choices.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff.

Staff ensured people's privacy and dignity was maintained at all times.

Staff respected people's needs to maintain as much

independence as possible.

Is the service responsive?

Good

The service was responsive.

People's care was planned and reviewed on a regular basis with them. The care plans fully explored the needs of people and how other agencies could help them.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Good

The service was well-led.

An analysis of audits was undertaken to measure the delivery of care, treatment and support given to people against current guidance.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

The views of visitors and other health and social care professionals were sought on a regular basis.

Holly Tree Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 12 December 2016 and was unannounced. The inspection was undertaken by an inspector.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority and NHS who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to health and social care professionals before the site visit.

During our inspection, we spoke with six people who lived at the service, three relatives, four members of the care staff, two registered nurses, a housekeeper who was also the activities organiser, a laundry assistant, a cook and the registered manager. We also observed how care and support was provided to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at five people's care plan records and other records related to the running of and the quality of

the service. Records included maintenance records, staff files, minutes of meetings and audit reports the registered manager had completed about the services provided.

Good

Is the service safe?

Our findings

People told us there were sufficient staff to meet their needs. One person said, "All my needs are met. I've been here well over [gave time scale] and never had to wait for anyone to help me." Another person told us, "All the time I've lived here which is [named number of years] I've had everything done for me. Never a problem." A relative told us, "They really do look after [named family member], as soon as we ask, it's done. You always see staff about all over the place."

Staff told us that the staffing levels were good. One staff member said, "We have sufficient staff, care staff and nurses. The nurses share roles and we liaise throughout the day to see where the greatest needs are for staff to respond too." We saw this take place and a staff member was asked to help out in a different part of the home so people could be ready for the afternoon's entertainment. Another staff member told us, "We have sufficient staff, you couldn't get better." Staff told us they could voice their opinions about staffing levels and felt those opinions were valued.

The registered manager told us how the staffing levels had been calculated, which depended on people's needs and daily requirements. These were reviewed on a regular basis by the registered manager. Where extra assistance was required at times for some people due to their needs becoming more complex, staff told us staffing levels were adjusted accordingly. There was a contingency plan in place for short term staff absences such as sickness and holidays, which bank staff fulfilled. Bank staff are staff who the provider employed to work on a needs only basis.

People who live in the home and relatives told us they felt safe living at the home. They told us they could have keys to their bedrooms if they required them. Although no one had taken that option. Relatives told us that staff observed people to ensure they did not enter peoples' bedrooms unless asked and gently diverted those people away if they could not remember where they were going to ensure people's belongings were safe. We observed this during the day. Staff speak quietly to someone and explained that they should not enter a person's room; the person appeared not to understand so staff offered a hot drink. This calmed the person and they moved away with the staff member.

Where there had been incidents where people's challenging behaviour could be harmful to themselves or others, staff had analysed the causes of people's behaviour. For example, when a person could not remember the people sitting next to them were not family members so could become over familiar in their actions to others. Consideration had been given to whether the person required an increase of observation and whether this had been discussed with the local authority safeguarding team. This meant staff had means of knowing the triggers which could result in a person's behaviour and would therefore help prevent them and others being harmed.

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the registered manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis. There was an analysis to show themes and trends, which would help to identify specific safeguarding concerns. Staff told us that changes in care needs were discussed at staff meetings and daily shift handovers, which they said was effective.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take positive risks to enhance their quality of life. We observed staff assisting people to use a variety of walking aids and wheel-chairs throughout the day. Staff gave reassurance and advice to each person on how to walk safely or use their wheel-chair around the building. This was to ensure each person was capable of being as independent as possible. For example, where people had a history of falls and difficulties mobilising around the home. Falls assessments had been completed. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person. Permission for the use of bedrails had been sought and were in place. This was recorded in each person's care plan. People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because of poor mobility problems or who would become anxious when hearing a loud noise. A plan identified to staff what they should do if utilities such as gas and water facilities failed and where to evacuate people to in case the building needed to be emptied. This had been last updated in January 2016, but the registered manager informed us the information was still valid. Staff were aware of how to access this document.

We were invited into eight people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. Staff had taken into consideration when writing the care plans of environmental risks for some people, especially those with mobility problems or loss of vision. This ensured rooms were free of trip hazards from trailing wires and ensuring furniture was in a good state of repair.

The main entrance to the home was through a reception area where people either rang a bell to summon staff to enter or who had authorised access by using a code. Entry to various parts of the building required a code. Staff told us that people could have access if they had been assessed as being capable of retaining that information and this was recorded in their care plans. We saw relatives using the code to gain access to a unit where their family member lived. Staff told they informed relatives not to pass on the code to others. Relatives told us this was correct. Some people had name plates on their bedroom doors, which enabled them to identify which room was theirs and could enter safely. Some people choose to have pictures on their bedroom doors which meant they could recognise them quickly. There were also signs on the doors indicating what each room was used for, for example, a bathroom or toilet. However, in one unit where people lived who mainly had memory problems there was little directional signs in corridors to direct people around the unit, other than fire exits. This could mean that people who had a poor memory could walk for a long time until they found where they wanted to be.

We saw that recruitment checks were carried out prior to people being employed at the service. The provider asked for two references, proof of identification and undertook checks with the Disclosure and Barring Service (DBS) to ensure that people did not have any past convictions that would present them as a risk to people living at the service.

People told us they received their medicines and understood why they had been prescribed them. One person said, "I get mine on time each day." They went on to tell us what was prescribed for them by their GP. A relative told us they knew their family member did not like taking medicines as they had witnessed this at

home. However, they said staff were excellent and had found alternative methods of ensuring the person could take their medicine with ease, such as some being in a liquid form. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in locked areas in each unit. Records about people's medicines were accurately completed. A separate register was kept for those medicines which were required to be recorded in a separate book and there was accurate recording by staff. The registered manager told us they had completed an internal audit of medicines in October 2016, which we saw. There had been no major issues to pass on to staff.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. Staff who administered medicines had received training. Reference material was available in the storage areas.

Good

Is the service effective?

Our findings

Staff we spoke with who had been newly recruited told us that the induction programme had suited their needs. They told us what the programme had consisted of which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. The registered manager told us that all new staff were now registered for the new Care Certificate. This would give everyone a base line of information and training and ensure all staff had received a common induction process.

We saw there was a training system in place commissioned through an external company. This system was flexible and enabled the provider to identify units each year that they felt would be most appropriate to the needs of staff at the time. Staff were expected to work through 'knowledge books' and then their knowledge would be tested and marked by the training company. This would then highlight where more training and development would be needed. There was also regular training around issues such as infection control, diversity and equality. Some staff had completed training in topics such as dementia awareness, bereavement and record keeping. The training matrix showed that training was up to date. One member of staff had undertaken further training to support them in their link role as infection control lead. They told us they were then able to cascade information to other staff members to ensure they were following safe procedures to protect people from harm.

Staff received supervision, according to the records. Some stated they had received this every couple of months, whilst others stated there was a more informal approach by their supervisors on when they required formal supervision. Registered nurses were independently seeking advice about their revalidation with the Nursing and Midwifery Council (NMC), but felt supported by the registered manager. This ensured they remained on the 'live' register with the NMC and seen fit to practice as registered nurses. The registered manager was checking the progress of the NMC revalidation process with each registered nurse.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirement in the DoLS. A number of applications had been submitted to the local authority and the registered manager was awaiting their authorisation. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS. Staff gave us a good explanation of what the MCA and DoLS would mean for the people they looked after.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times best interest meetings had been held after assessments had been completed to test their mental capacity and ability.

People told us that staff would contact other health and social care professionals if they needed them. There was evidence in the care plans that staff had arranged visits and sought advice from a number of health and social care professionals, as well as family and friends. In the care plans there was evidence of joint agency working to ensure people could access all the resources they required. For example, there were details of different health care professionals being asked to treat people or had been contacted for advice. This included occupational therapists, physiotherapists, community mental health nurses, chiropodists and opticians. This resulted in people receiving the appropriate care to meet their needs.

People told us that they liked the food. They told us the meals were varied and they had choices each day and never felt hungry. One person said, "If I don't' like something they will make me what I like." Another person said, "I'm very happy with the food." Two relatives told us they were offered refreshment on arrival and could also have a meal with their family member, which they sometimes accepted. They told us the meals were well presented, hot when required to be and they were offered hot and cold drinks throughout the day. One relative said, "[Named relative] is eating well, much better than they used to. I think because meals are a social occasion."

Staff knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet and if they needed assistance. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes, foods to avoid and the type of diet required. This ensured people received what they liked and what they needed to remain healthy.

People told us they could choice their meal the day before, but were always asked on the day if they still would like their choice. Menus were on display in the dining rooms and also within the kitchen area. The menus were in the process of being changed, but staff told us people had been consulted about the changes and their views taken into consideration. People told us kitchen staff asked them at meal times about the quality of food and had been recently asked about menu changes. We saw this written in a diary. We saw that staff ensured people were well hydrated during the day. People were offered hot and cold drinks regularly by staff, but staff also made drinks for people when asked to do so. Staff took meals to people who preferred to eat in their rooms. They ensured each person was sitting comfortably and had all the utensils and condiments they required.

We observed the lunchtime meal, which staff told us they treated as a social occasion with music playing and ensuring the tables were set with tablecloths, napkins, cutlery and condiments. We observed staff sitting with people who needed help to eat and drink. They spoke kindly to them, maintaining eye contact and informing them what was on the plate or bowl. Staff did not hurry people. Staff were calm, gave encouragement to get people to eat and ensured people had something to eat. We observed that when people had food on their face staff asked whether they could wipe this away, which they did gently. When food had been spilt on clothing staff asked if the person would like to change and guided them to their bedroom.

We heard staff speaking with relatives about hospital appointments and home visits, after obtaining

people's permission. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made. People told us they had appropriate and timely access to health care. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people's health care needs had changed and when they required health checks such as flu vaccinations and over 75 years reviews. The over 75 years reviews were undertaken by other health professionals to monitor people's well being as they became older and used as well as a preventative measure if people were experiencing problems with their health as they became older. One person said, "If I need a nurse or doctor staff will arrange for them to come, or will take me. It's a good service." Another person told us, "I've needed some specialist help recently. Staff have worked hard liaising with hospitals, doctors and the like. They've been wonderful. I couldn't do it on my own." A relative told us their family member had to go to hospital recently and staff had accompanied them as no family member could go. They told us staff had fed back to them the outcome and they had opportunity to arrange to speak to the hospital staff if they wished.

Good

Is the service caring?

Our findings

Staff approached people in a kindly manner. They showed a great deal of friendliness and consideration to people. They were patient and sensitive to people's needs. We saw staff took time to respond and engage with people who spoke to them. For example, when someone was becoming distressed after their family left. Staff sat with the person and reassured them their family would return another day.

We observed staff discussing with someone about their bath that afternoon. Staff ensured they had all the necessary soaps, body lotions and towels the person wanted to use. The staff member talked with the person about the temperature the person required the water to be and whether they wished to be left alone. People told us bathing and showering used to be an event in their own homes, but now it was an occasion to look forward to as staff made it enjoyable.

People told us they liked the staff and felt well cared for by them. One person said, "I've been well cared for here and it's down to the staff." Another person told us, "I like all the staff because they treat everyone the same, but they make every one of us feel special." A relative told us, "I'm happy [named relative] is here. The last place didn't' suit them. This is a different set up much friendlier."

People were given choices throughout the day if they wanted to remain in their bedrooms or where they would like to sit. Some people joined in happily and readily in communal areas. Others declined, but staff respected their choices on what they wanted to do. There were also quiet areas in corridors where people could sit. We observed people in those areas, some with their relatives and other people, and some with staff. There was a lot of laughter and conversation taking place.

Some people either through choice or because they were ill choose to remain in bed. We observed staff attending to people's needs. They ensured they answered people's call bells promptly and politely asked what they required before fulfilling the person's wishes.

The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. The way people wished to be communicated with was included in the care plans. For example some people used sign language, other preferred to be called by their first names, whilst other preferred a prefix to be used such as "Mr". We observed staff respecting people's wishes when speaking with them. They also gave people the time to express their wishes and respected the decisions they made. For example, one person wanted to sit in the same chair after each meal. Staff asked whether they would like a different view of the home from a different room, but the person declined and staff respected their wishes.

We observed staff helping several people whose behaviour was challenging to others. We observed staff handling situations where people's behaviour was disruptive to others and could put them and others at risk of harm. Staff were calm, talked with each person and offered alternatives to how they would like to spend their time and where they could sit. People and relatives told us staff dealt well with those situations and they felt safe. When talking about the behaviour of some people, a relative told us how staff had dealt

with a situation. They said, "Staff have a lot of patience. It's sad when people can't remember, but I've never witnessed a volatile situation, I suppose because staff are so calm." Staff told us they dealt with each situation quickly so people would not be alarmed and would feel safe.

Relatives told us how staff had supported them when their family members were very ill. They told us staff had been very comforting to them as well as their family members. They had been kept informed about events and felt included in discussions. Staff were described as kind and knowledgeable. A relative told us, "Recently it's been difficult to think of a loved one declining, but staff have kept us positive so we can have an enjoyable visit." People told us their relatives could visit them whenever they liked. One person said, "[Named relative] comes any time I want them too."

We saw signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis. This ensured people could still have contact with their own families and they in turn had information about their family member. Staff told us they kept interruptions to a minimum when people had visitors as they wanted people to enjoy their visit. People told us staff would telephone their family members when they wanted to speak with them.

People told us staff treated them with dignity and respect at all times. They said staff closed doors and curtains when attending to their personal hygiene needs and never left them exposed when in a bath or shower. People said if staff had to discuss personal matters with them such as hospital test results they would do so in the privacy of their bedrooms. We observed staff asking a person if they would like to go to their room as they needed to discuss their medicines. The person declined, but the staff member spoke to them in quiet tones and ensured no one else was listening to the conversation. We saw staff discreetly adjusting a person's clothing as they came out of a toilet as the person had forgotten to check themselves. The person laughed and thanked the staff member.

We observed staff knocking on doors prior to being given permission to enter a person's room. They asked each person's permission prior to commencing any treatment and respected if they wanted pain relief medication prior to commencement of treatment.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local lay advocacy service on display. There were no local advocates being used by people at the time of our visit.

Good

Is the service responsive?

Our findings

The home is split into two units and the registered manager told us people were assessed with a view of initially staying in the unit which best suited their immediate needs. As staff became more familiar with people's needs and wishes there was then opportunity for them to move to a different unit within the home.

In the care plans we looked at the reason people had been admitted was recorded. It was clear why they were at the home and if the setting was appropriate to their needs. There was a risk history for people leading up to their placements at this home. For example, in one care plan it stated the person was local to the area and would benefit from people visiting who they knew from the surrounding villages. Another person had been admitted as the home could satisfy their nursing needs as there were always registered nurses on duty through a 24hour period.

There was clear information in assessments and care plans to show all aspects of a person's life were considered. This included the potential for physical needs to impact on their mental well-being in situations such as following a stroke. Assessments had been undertaken to ensure not only the person's physical needs were being considered, but also their mood swings and depression from loss of ability to fend for themselves.

Staff had always recorded what actions they had taken when people had specific needs around their continence needs. When and why catheters had been replaced had been recorded, plus details on each catheter used such as a batch number. This ensured if there was a problem staff could refer this back to the supplier. The type and frequency of incontinence aids in use had been recorded, which helped staff to order sufficient supplies.

The wording in the care plans showed the care plans were written with people, as opposed for them and their views were being recorded. Staff told us care plans were to be updated every month and this was in all care plans we reviewed. People and relatives told us they had seen their care plans and been involved in the planning of their care. Consent to obtain information on people and share with other professional agencies were in each care plan. These had been signed by the person themselves or their advocate.

The people we spoke with gave us positive views about the response times of staff to their needs. They told us staff responded to their needs quickly. People told us when they used their call bell this was answered promptly day and night. We heard call bells sounding and staff answered these very quickly. When an emergency bell sounded staff ensured someone was in communal areas where people could not be left alone and other staff answered the alarm bell. Once the emergency had been assessed a minimal number of staff remained with the person and others returned to their work.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use.

We were informed by the registered manager that an activity co-ordinator was employed on a part time basis and we spoke with that person. They told us their hours were flexible and this ensured that social activities could take place any day of the week if necessary. Staff told us activities were arranged through consultation meetings with people. A programme was on display for December 2016 and we saw the advertised activities taking place. People told us they enjoyed such events as the entertainers which visited, board and card games and exercise to music. All of which were recorded in the activities records of each person. People also told us they liked sometime on their own and staff ensured they had a working television to watch and radios to listen to and had a supply of books, newspapers and magazines, if they required them. We observed staff sitting with people to watch a television programme, which they discussed with person. Another staff member was reading the headlines on a national newspaper to someone who could no longer read easily. Staff were trying to access some more courses to help them plan a programme of social activities for those with problems with their memory. They had included reminiscence sessions on their programme of events, but felt more could be achieved.

Links with the local community had been encouraged. People told us of visits they had made to family, local restaurants, the local public house and the local church. One person said, "When the weather is warmer we go for walks around the village. Locals know us and stop to chat. It's lovely being part of a village." The local dramatic society also performed in the home. Staff had recently obtained some articles from the local museum to use as reminiscence aids for people who had memory problems.

The provider had a system for managing complaints and this was available in the entrance of the service for people to access. We reviewed the complaints information and there was one record of a formal complaints having been made since our last visit. This had been dealt with appropriately. People and relatives told us they knew the process for making a complaint and would not worry about doing so if the need arose. Staff gave a good explanation of what they would do if someone wanted to make a concern or complaint about the level of service they were receiving.

Good

Is the service well-led?

Our findings

There was a registered manager in post. People and relatives told us they could express their views to the registered manager and felt their opinions were valued in the running of the home. One person said, "The manager and all the staff actually are lovely. The manager has been here a long while, she is confident in her job and knows all about us." One relative said, "I can go and see the manager when I want, but she is always here, visible around the home. I don't know when she goes home." Staff told us they felt supported and could influence change by talking with the registered manager.

The registered manager told us they received good support from the owners of the home. They rang each day and visited at least once a fortnight. People who used the service, relatives and staff told us they had opportunity on visits by the owners to speak with them and they always appeared interested in what was going on within the home. On display was a notice for staff which reminded them of six things they should remember when looking after people. This was called the six C's and listed words and consequences of care, compassion, competence, community, courage and commitment, which staff were asked to follow. People, relatives and staff told us they felt this was a good view of the home and the standards they maintained. One person said, "I call this place my home. There is nothing like it anywhere else." Another person told us, "I wouldn't move for the world." A relative told us, "Staff are like family to us too." A staff member said, "I just don't feel as if I'm coming to work."

Systems for auditing and monitoring the service were in place and these were all kept up to date. These included care plans, infection control and kitchen audits. There was a maintenance schedule which listed work which had been planned in 2016. This did not always give the detail of when some work had been completed, but we could see that work such as window restrictors being replaced, refurbished or mended had taken place and boilers been replaced. There was a system for following up any gaps or shortfalls identified in the auditing process. The audits that had been completed effectively identified areas for improvement. Staff told us information would be given at staff meetings, handover and supervision sessions.

The registered manager told us they preferred to speak with people on a daily basis and would record in the care plans their conversations with people, especially when changes to their care needs, suggestions about the environment and about staff were required. We saw details of such in the care plans we reviewed. A questionnaire had been sent out in August 2016, which covered a number of topics and the results were on display. We saw it was in two sections, what people had asked to be completed or reviewed and what action had taken place. For example, the phone system not being adequate as this was a rural area and a new one had been installed. There was also a suggestion box next to the registered manager's office, which people knew about and they could drop in suggestions. A recent one had been about security in the car park, which was being currently reviewed.

Staff told us they had the opportunity to speak at staff meetings and felt their opinions were valued. For example we saw notes of a meeting that described the processes for good infection control processes to be practiced by staff. The notes recorded the questions staff had asked and responses given. Staff told us they

were never left without an explanation to a request or problem.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The registered manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

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