Hazeldell Ltd

The Willows

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

The Willows is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. This service is registered to provide nursing care, but this service was not provided at the time of our inspection. The Willows accommodates up to 66 older people, some living with dementia.

On the day of our comprehensive unannounced inspection on 24 October 2018, there were 33 people living in the service. The Willows was registered with the Care Quality Commission in November 2017, this was their first inspection.

There was a registered manager in place. The registered manager was working as the operations manager. There was a new manager in place, their registered manager application was being processed. 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.

People received a safe service. The risks to people were assessed and staff were guided how to reduce these risks. Staff were trained in safeguarding people from abuse and where incidents had happened the service learned from these to drive improvement. There were systems in place to assess the numbers of staff required to meet the needs of the people using the service. Staff recruitment processes reduced the risks of staff being employed in the service who were not suitable. There were systems in place to manage people's medicines safely. Good infection control practices were in place to reduce the risk of cross contamination.

People received an effective service. People were supported by staff who were trained and supported to meet their needs. People had access to health care professionals when needed. Staff worked with other professionals involved in people's care. People's nutritional needs were assessed and met. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The environment was well maintained and suitable for the people using the service.

People received a caring service. People shared positive relationships with staff and their privacy, independence and dignity was respected. People were listened to in relation to their choices, and they and their relatives, where appropriate, were involved in their care planning.

People received a responsive service. People's individual needs were assessed, planned for and met. People had access to social activities to reduce the risks of isolation and boredom. People's choices were documented about how they wanted to be cared for at the end of their life. There was a complaints procedure in place and people's complaints were addressed.

The service was well-led. There was a programme of audits in place which demonstrated that they assessed and monitored the service provided. Where shortfalls were identified actions were taken to improve. People were asked for their views about the service and these were valued and listened to. As a result, the service continued to improve.

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.

Risks to people were assessed and mitigated. This included risks in the environment, people's daily living and risks associated with abuse.

The staffing levels were assessed to provide people with the care and support they needed.

There were systems in place to manage people's medicines safely.

The service had infection control policies and procedures which were designed to reduce risks to people.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and supported to meet their needs.

People's nutritional needs were assessed and met. People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

The Deprivation of Liberty Safeguards (DoLS) referrals had been made appropriately. People's capacity to make their own decisions was assessed.

The environment was suitable for the people who used the service.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected.

Staff treated people with kindness and they knew people well.

Staff and people shared positive relationships.

People's choices about how they wanted to be cared for were respected and listened to.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed, planned for and met. People's end of life decisions were documented.

There were systems in place to support people to participate in meaningful activities.

There was a system in place to manage people's complaints.

Is the service well-led?

Good

The service was well-led.

The service had quality assurance systems to identify shortfalls, address them and use them to drive improvement.

The service provided an open culture. People were asked for their views about the service and these were used to improve the service.

The Willows

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 unannounced comprehensive inspection took place on 24 October 2018 and was undertaken by two inspectors, and an 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.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with 12 people who used the service and six relatives. We observed the interaction between people who used the service and the staff throughout our inspection.

We looked at records in relation to five people's care. We spoke with the operations manager (registered manager), the manager and seven members of staff, including catering, domestic, administration, care and senior care. We looked at records relating to the management of the service, six recruitment files, training, and systems for monitoring the quality of the service.

Good

Is the service safe?

Our findings

People told us that they were safe living in the service. One person said, "I'm glad I'm living here, I feel safe and I've settled in." One person's relative told us, "I'm really happy [family member] is here, [they are] warm, safe and cared for. There is also a patient safe to keep [family member's] belongings safe."

Staff received safeguarding training and understood their roles and responsibilities in reporting safeguarding. There were notices in the service advising of how to report safeguarding.

Care records included risk assessments which provided staff with guidance on how the risks to people should be minimised. This included risk associated with mobility, pressure ulcers and falls. Where people were at risk of developing pressure ulcers systems were in place to reduce these, this included seeking support from health care professionals and the use of pressure relieving equipment.

Where people were at risk of falls, actions were taken to reduce future risks. This included referrals to health care professionals to obtain guidance and the use of equipment to reduce the risks of falls. One person said, "If I do fall I have rung my alarm and they come running upstairs." Incidents of falls and accidents were analysed by the manager with control measures in place to reduce future incidents.

Risks to people injuring themselves or others were limited because equipment, including hoists, and fire safety equipment, had been serviced and checked so they were fit for purpose and safe to use. Records showed that gas and electrical installations had been assessed as safe. Portable electrical equipment was being checked on the day of our inspection visit to ensure they were safe. Risks associated with the environment were assessed with control measures in place. There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire. Fire safety checks were undertaken and there were personal evacuation plans (PEEPs) in place for each person to ensure that staff were aware of the support that people needed should the service need evacuating. The PEEPs were kept in a file at the front of the building and people had a copy of their PEEP on the back of their bedroom door. One person said, "When the fire alarm goes off I stay in my room to stop the fire coming through."

There was a legionella policy and procedure and there was a provider's risk assessment. There were systems in place to check water temperatures to assess if there was a potential risk of legionella. However, there was no formal risk assessment undertaken by a qualified person which identified, for example schematics and dead legs in the service. The service was newly built and this reduced the risks. The operations manager told us that they had requested a quote for this to be completed.

We received varied comments from people who used the service and their relatives about if they felt that there were enough staff in the service to support them. Some people and relatives said that they felt that the staffing was sufficient, others said that it was not. One person said, "It's not easy but the girls have so many people to look after; they could do with a bit more staff." Another person commented, "I think there is enough staff." One person's relative said that they felt that there were not enough staff. Another relative told us, "It's difficult to say if there is enough staff, it is adequate." Another relative commented, "They are

probably understaffed, they do have a lot to do."

We saw that staff responded to people's requests for assistance and were available when people needed support. People commented about if their requests for assistance were addressed promptly. One person said, "When I ring my alarm sometimes there are two staff come rushing in at once." Another person commented, "We are alright here. I ring my bell to come out or go to the loo. Sometimes it can be a bit of a drag, it depends on how busy they are, they do well." One person's relative said, "We have rung the alarm, they are quick to respond, normally within five minutes, once it took a bit longer as [family member] needed hoisting. The alarm screens in the corridor are very good as staff can see who needs assistance."

The manager told us how the service was staffed, which was confirmed in the rotas. The service used a tool which assisted with the calculation of the staff numbers needed to meet people's dependency needs, this also considered the layout of the service. The manager reviewed this tool regularly to ensure that the needs of people were met by appropriate numbers of staff. The manager told us that the staffing was currently more than the calculated need, this was confirmed by records. Staff, including domestic staff, were trained in care and the manager said that if someone needed urgent assistance this could be delivered by all staff. The manager told us that they did not use agency staff. If there were any need for more staff, such as short notice leave, they used staff from another of the provider's services or called on existing staff to volunteer to cover shifts. If concerns were received by the management team these were looked into and addressed. Therefore, the systems in place were appropriate to assess staffing requirements.

Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

People told us that they were satisfied with the arrangements for their medicines administration. One person said, "I have three pills in the morning and they always come." One person's relative said, "They do give [family member] tablets every four hours and pain killers."

We observed part of the administration rounds during lunchtime, this was done safely. The medicines administration records (MAR) identified that people received their medicines when they needed them. There were some discrepancies in the MAR but the risks had been mitigated. The service's weekly and monthly audits in medicines had picked up the recording issues and action was taken to reduce the risks to people.

Some people were prescribed medicines to be taken as required (PRN). There were protocols in place for these medicines to guide staff on when they should be considered to be given to people. People told us about how they were provided with these medicines when they needed them. One person said, "If you can't sleep at night because of pain they always offer you paracetamol." Another person commented, "If I say my leg is a bit sore they say let's get some cream."

Records showed that staff who were responsible for administering medicines had received training and had their competency checked by the management team. A staff member told us that they had received training in medicines, was observed for two shifts then was assessed on their competency. Medicines were kept safely in the service and there were safe systems in place for the ordering and disposal of medicines. Regular checks were undertaken, these included temperatures, stock balance and audits.

The service was visibly clean throughout. Staff told us that they were provided with enough equipment and there were enough staff to clean the service. Infection control audits were carried out to allow any shortfalls to be quickly addressed. Staff had received training in infection control and food hygiene. There were

disposable gloves and aprons that staff could use, such as when supporting people with their personal care needs, to reduce the risks of cross contamination. These were available throughout the service to allow access. In addition, bathrooms provided disposable paper towels and hand wash to use to reduce the risks of cross contamination. We noted that on the first floor there were no bins in the toilets to dispose of the paper towels. These were ordered immediately.

Good

Is the service effective?

Our findings

People's care needs were assessed, planned for and delivered holistically. This included their physical, mental and social needs. There was an assessment process which was completed prior to the person moving into the service. This included visiting them at their own home, other care service or in hospital to discuss their needs. This assisted a smooth transition between services. One person's relative said, "It was a fantastic admission. We came and had a look round, it was very friendly, open, and the environment seemed an optimistic one for [family member] to be in."

Discussions with staff demonstrated that the service worked with other professionals involved in people's care to ensure they received a consistent service with specialist input when required. This included the commissioners for services and health care professionals.

Staff told us, and training records showed that staff received the training that they needed to meet people's needs. This included training in moving and handling, medicines, safeguarding, basic life support, fire safety and health, safety and welfare. In addition, staff had received training to meet people's specific needs and preferences including dementia, end of life, diabetes, and equality, diversity and human rights. The training provided was face to face and electronic learning. The manager told us that all staff working in the service received the same amount of training. This was confirmed by records and a member of the domestic team we spoke with. They said that they had received the same training as the care staff and if needed they felt they were trained to provide support to people. The manager told us that work was ongoing to support to senior staff in the development of their skills as supervisors and requirements of their roles.

New staff received an induction course which included training and shadowing more experienced colleagues. Where new staff had not completed a recognised qualification in health and social care, they were supported to complete the Care Certificate. This is a recognised set of standards that staff should be working to.

Staff told us that they were supported in their role and received supervision. Supervision and staff meetings provided staff with a forum to discuss the ways that they worked, receive feedback, identify ways to improve their practice and any training needs they had. In supervisions staff also discussed their understanding of the service's policies and procedures and their roles and responsibilities.

People's told us that they were provided with a choice of meals and that they got enough to eat. One person said, "Once they said did you enjoy your dinner and I said no, I'd prefer ice-cream, and they said okay, ask for that next time and you can have it; nothing is too much trouble." Another person commented, "It's alright, I can't complain, you get good meals here." Another person told us, "I don't eat much, I eat what I want and leave the rest." One person said, "I don't like the food." One person's relative said, "The food is really nice, there are options, if [family member] refuses something they offer an alternative. They have asked [family member] what [they] like and don't like, they always give [family member] small plates of food which is so important for [them]." Another relative commented, "[Family member] says the meals are nice."

During lunch we saw that people were offered choices of what to eat. Staff offered people assistance, such as cutting up their food. Where people required assistance to eat their meal, this was done appropriately, and at the person's own pace. We noted that people who ate in their bedroom or not at the dining table, had a small table to eat off, this was not height adjustable so the person had to lean forward to eat. We told the manager what we had seen and they immediately ordered more appropriate tables, which could be adjusted and allow people to eat their meals more comfortably.

People told us that they got plenty to drink to reduce the risks of dehydration. One person said, "They make sure I get plenty of cups of tea." People's records identified the minimum amount that people should drink each day.

People's records included information about how their dietary needs had been assessed and how their specific needs were met. This included people who were at risk of choking or malnutrition. Where people were at risk of not eating and drinking enough, this was monitored and people were encouraged with their nutritional requirements. Other professionals were contacted for guidance and support to meet people's needs, such as dieticians and speech and language therapists (SALT). One person's relative told us, "[Family member] is now refusing food and drink, they come round periodically and offer [family member] food, nibbles, drinks, fresh fruit. They are supporting [family member] as well as they can depending on what [they are] capable of." Another relative raised concerns relating to their family member's condition and the choices they were offered during meals. We spoke with the manager about choices, capacity and conditions, they were clear on people's capacity and rights to make their own informed choices if they had been assessed as having capacity and specific foods were made available to meet people's needs.

Staff spoken with, including catering staff, understood people's specific dietary needs and how they were met. This included people who required a softer diet and those who needed a fortified diet and drinks to boost their calorie intake and maintain a healthy weight. The manager told us how the menu incorporated cultural food to reflect the community living in the service. This was on offer to all people to enable them to try the food provided. People were asked for their views on the food provided and amendments were made to the menu, where required.

People told us that they felt that their health needs were met and they were supported to see health care professionals if needed. One person said, "I spoke to the nurse this morning about a little lump that has come up under my eye, [they] said the next time the doctor visits we will get him to see you." Another person commented, "The doctor comes round sometimes to see you and I've had a flu jab." Records showed that where there had been concerns about a person's health, they were referred to health professionals and any advice and treatment was recorded. Some people demonstrated behaviours that may be challenging to others. Records identified that actions had been taken to seek specialist advice from professionals to ensure the required level of support was put in place.

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.

People's care records included if they had capacity to make their own decisions. If people lacked capacity there were systems in place to assist them. There were records of best interest decisions in place and DoLS referrals had been made appropriately. People's care plans incorporated information about the DoLS and how this affected the way that they were supported. Training records identified that staff had received training in the MCA and DoLS. Staff asked for people's consent, for example where they wanted to spend time in the service and if they needed any assistance with their meal. People had signed their records to show that they consented to the care provided. Where people were unable to sign they had been signed by their representatives including relatives.

People were complimentary about the environment and how it met their needs and choices. One person's relative said, "We are pleased with [family member's] room and [have their] own chair which was important for [family member]."

The service was new build and there had been some identified issues. The service had contacted the contractors and the remedial work was being completed. This included painting and repairing a crack in a wall in an area which was only accessible to staff.

The environment had communal areas that people could use, including lounges, dining area, conservatory and a library. There was a hairdressing salon, which resembled high street salon. There was a cinema on the first floor, the operations manager (registered manager) told us that people tended to use the same communal area on the ground floor where there was a large television screen, but they were looking at ways of using the cinema more. There were areas in the service where people could see their visitors in private. The facilities were designed and adapted for use by people with limited mobility and users of wheelchairs, with wide corridors. Bathrooms had wide doors, and grab rails in the corridors and bathrooms. There were gardens which people could use. People could access the secure gardens and take part in its upkeep. One person said, "I potter about in the garden here or watch the telly. I did a few hours in the garden on Tuesday." There were pictures throughout the service of movie stars and pop stars from the past.

The manager and the operations manager (registered manager) told us that they had been nominated for a national award for the dementia friendly environment. There were different coloured doors to help people to navigate around plus signage. However, the signage may benefit from being larger to assist people to see them easily. There were Perspex notices on each floor included text, room numbers and arrows were not easy to see because the text was small and the light reflected off them. People's bedroom doors had their names on them at the top right of the door. These may benefit from being larger to assist people to see them and possibly include a picture or items of memorabilia to aid familiarity. In addition, if people used a wheelchair to mobilise it would be difficult to see their names due to their position on the doors. We discussed this with the manager and operations manager (registered manager) who said they would look at improving this.

Good

Is the service caring?

Our findings

People spoken with said that the staff were caring. One person said, "In the night they will make you a drink if they can see you are awake and fidgeting. The care here is excellent. I [had a bereavement] recently and couldn't stop crying, the staff were amazing, so patient, you couldn't be better looked after." Another person commented, "The other day I was on the toilet and I had a touch of vertigo. I pulled the cord and a young [staff member] came, put me in a wheelchair, poured me a drink, [staff member] was so good." Another person told us, "They are all very good staff, they help you a bit, if you get in a muddle. They look after the patients." Another person said, "The care is fine, the carers are fine, kind, all understanding and most of them go out of their way to please you." Another person listed the staff and said that they were all caring and treated them well. We saw cards and letters sent to the service thanking the staff for the care and support provided and their caring attitude.

There was a relaxed and friendly atmosphere in the service and people and staff clearly shared positive relationships. This included positioning themselves at people's eye level to engage in effective communication. Staff spoke to and about people in a compassionate way. They clearly knew people well. One staff member said, "We look after people here like we would our own parents or grandparents."

The manager shared examples of how they provided a caring service. This included taking a person who used the service to visit their relative in another care service to celebrate an important event.

People told us how their independence was promoted and respected. One person said, "I can feed, wash and dress myself." The manager told us, and records confirmed, about a person who was able to access the community independently and this was supported. The manager had made up a card for the person to take out with them with the service's details in case anything happened when they were out. This supported their right to independence but recognising the risks associated with it.

People's care plans guided staff to ensure people's privacy, independence and dignity was respected. An example of this was one person's records guided staff how to promote their dignity if they had experienced incontinence. One person said, "When they wash my back, they cover my privates with a towel." Staff knocked on bedroom and bathroom doors before entering. We saw one person using the toilet and they did not close the door. A member of the domestic team noticed this promptly and went to the door spoke quietly to the person and closed the door to respect their privacy. A person's relative told us how they felt that their family member's dignity was respected, "[Family member] always looks clean, [they had their] hair permed recently. I've never heard any staff say they couldn't do something. Here they always take [family member] to the toilet or put [them] on the commode, rather than lay [them] on a bed pan like they do in the hospital."

People told us that they made choices about their daily lives and the staff acted in accordance with their wishes. One person said that the staff helped them with their choices by reading out what was on the menu, because they could not do it themselves. People's records clearly identified their preferences and usual routines so the staff providing care were aware of these and met people's needs in accordance with how

they wanted to be cared for. The records also included people's likes and dislikes and choices such as the gender of staff member they preferred.

People told us that they could have visitors when they wanted them, which reduced the risks of isolation and loneliness. Records included information about the relationships that people maintained which were important to them. One person's relative said, "They [staff] are always welcoming, they are always very nice." Another relative said, "We always get a smile and a welcome. We are offered tea and biscuits."

Relatives commented about if the staff kept them updated about their family member's wellbeing. One relative said, "You can stop them in the corridor and they will update you. If we have any concerns they follow them up. They are good at communicating, they rang to say [family member] has to go into hospital and when [family member] was coming home. They have rung to say we are sending off stool and urine samples." Another relative commented, "There certainly have been conversations, they say [family member is] a bit down or been helping in the garden. I'm always made welcome." Another relative commented, "They do update me with how [family member] is and if anything has gone awry."

Good

Is the service responsive?

Our findings

People told us that they felt that they were cared for and their needs were met. One person said that their health had improved since they had moved into the service and felt they were well looked after. Another person commented, "If you paid 100 pound a week you couldn't be looked after better." Another person told us, "It's very nice being with all different people. I feel comfortable, the staff are lovely, the food is nice." Another person said, "I quite enjoy living here." Another person told us, "I get looked after reasonably well. I get a shower two times a week. The carers are very good, they make sure I have what I need. I couldn't find fault with them at all." One person's relative said, "[Family member] has only been here a little while but the care from what I've seen is really first class." Another relative told us, "The care seems very good; the staff are very helpful. They are patient and attentive, they always keep [family member] nice and clean, [they] had a haircut, is really pampered." Another relative commented, "To be fair I find the carers certainly do their best. I wouldn't criticise them, they spread themselves as far as they can."

People's care records demonstrated that they received care which was tailor made to their individual needs. The records were written in a person centred way which guided staff in how people's preferences, routines and needs were to be met. People's specific needs were identified in the care plans and how these needs were met. Some people who had conditions which may affect their wellbeing, their care plans identified the impact on their daily lives and any warning signs staff should be aware of, such as signs and indicators of becoming unwell. Clear guidance for staff in how to support people with behaviours that may challenge others and the triggers to their distress, which should be avoided.

People told us about the activities they could do. One person said, "It's lovely to go out in the garden, staff push me in my wheelchair. I do word search, I have a book, newspapers, I'm not unhappy a bit. We have entertainment, I love singing and when you have enough they bring you back. I have my hair done every week… [staff member] is going to take me Christmas shopping nearer the time. I want to stay here for Christmas, there will be lots going on." Another person commented, "I help out a bit, take the crockery through, clean the tables. Yesterday we did a flower arrangement." Another person told us, "The activity [staff] came in this morning and brought me the flower arrangement I did yesterday. I don't get lonely, I'm not a lonely person." One person who preferred to stay in their bedroom said, "I spend most of my time in here, I'm not one to go and be with a whole host of people. I do occasionally get lonely, staff do come in and chat with me." One person's relative said, "Staff come in and chat with [family member]."

People participated in a range of activities during our inspection. This included word games, with all people in the communal area being encouraged to take part. A staff member asked a person what music they wanted on and they said they did not want to choose. The staff member put on music which made this person stand up and start singing, the staff member clearly knew the person well and what they liked. When the person finished singing the song staff applauded them.

The manager told us about activities which they had introduced into the service including a reggae choir, a local theatre company who visit the service. They were also in the process of seeking, a gospel church to visit the service, in addition to the existing monthly communion. They had worked with a local pre-school with

children visiting the service to spend time with people. They said that following changes in the pre-school staff they were planning to re-establish the relationship. The manager told us, people liked to have children visit and responded positively to this. There was a tablet computer in the service and the manager told us that they could download talking books for people, if required. The manager planned to complete a newsletter document to provide to all people in the service. This would include the social group activities on offer and also include things such as puzzles that people could complete themselves.

People's records included their social and emotional needs, including guiding staff to ensure that they received one to one time from staff. In addition, if people liked to help around the service, such as folding linen and preparing tables for meals, this was included in their records. The manager told us that they had introduced the 'sparkle' system where people were asked what they would like to do to fulfil a dream. This was confirmed in records examined. The manager told us how one person had been taken to a football match, had a three-course lunch at the ground and had met a 'legend' of Ipswich Town. The manager was working on making another person's sparkle dream come true who used to be in the Navy.

There were changes in the activities staff with a new second activities coordinator starting in November 2018. The other activities coordinator was also new and was getting to know people and what they liked to do. The activities coordinator was working on life story books with people. They had also done flower arranging and were busy completing things for Halloween celebrations.

People told us that they knew how to make a complaint and that they were confident that their concerns and complaints would be addressed. A person's relative told us that the manager always acknowledged their concerns and made improvements. However, these did not always stay in place. One person said about a concern they raised with the manager about staff, "I complained, and the manager put them straight." There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. The operations manager told us they were planning to introduce a central record of concerns which had not developed into formal complaints to provide an audit trail of how these had been addressed. This would run alongside the formal complaints process.

People's records included their decisions about the care they wanted to receive at the end of their life. For example, if they wanted to be resuscitated, where they wanted to be cared for, specific choices relating to their care at the end of their life and any arrangements they had made for their funerals. The manager told us they were working with a local hospice to complete an end of life care accreditation. This included training for staff and shadowing with staff from the hospice working in the service and staff from the service visiting the hospice. The manager said that they had arranged for the hospice staff to visit at nights as recognised that there was a risk of missing night staff out. Staff had received training in end of life care.

The manager understood that relatives and people did not always find it easy to discuss end of life choices but recognised the importance of this and encouraged open discussions. The manager showed us an e-mail received from the relatives of a person who had received end of life care. This thanked the staff for their care, patience and understanding of the person and their family. The manager told us about the services that they accessed to support the person at the end of their life, including pre-emptive medicines to ease their pain.

Good

Is the service well-led?

Our findings

Since the initial registration of the service in November 2017, there had been changes. The service was registered to provide nursing care in March 2018, however, there were no people currently using the service who required nursing care. The provider was considering if the service would be providing nursing care or not, they were aware of the changes they needed to make to their registration if this was not required. The registered manager was now working as the operations manager and there was a new manager in place. The new manager had applied to be registered with the Care Quality Commission, this was being processed. The manager was being supported by the operations manager.

The manager had a good understanding of people's needs and was able to provide us with information about individuals promptly. The registered manager was visible in the service and we could see that people knew who they were and responded to them positively. The manager was passionate about providing people with a good quality and person centred service at all times. One person said, "The manager is very nice."

There was an open culture in the service. People and relatives were involved in developing the service and were provided with the opportunity to share their views. This included quality assurance questionnaires. People and their relatives could also attend meetings to discuss the service. The minutes of each meeting held an analysis completed by the manager which showed that people's comments were valued and acted on to improve the service. This included obtaining more books for the library and starting reading sessions.

There was a programme of audits which were used to monitor the service provided. This included audits in falls, care plans, medicines and infection control. There were actions in place where shortfalls had been identified, to improve. The operations manager told us that they visited the service at least once a month, and undertook quality assurance checks. Action plans were formulated and these were monitored to show when the improvements had been implemented. Records confirmed what we had been told.

Staff were positive about the manager and working in the service. One staff member said that they loved working in the service. Another staff member told us that at their interview they were told that the service was anti discriminatory. The staff member felt that this was true and the staff team worked well together and all were treated equally. Another staff member said, "This is the best place I have ever worked, good atmosphere." Another staff member commented that they felt that as well as caring for the people who used the service the manager also cared for the staff.

Staff meetings were held where they discussed any changes in the service and in people's needs. The minutes of staff meetings also showed that they were reminded of their roles and responsibilities including ensuring people had enough to drink, the security of the building and that they had completed the training required.

People's records held consent forms relating to how their personal data was kept. This showed that the service had kept updated with changes in regulation.

As part of our planning we looked at how the service made notifications to us. Notifications are incidents that should be made to us relating to deaths and incidents in the service. The service had appropriately notified us of incidents, the actions they had taken and how they planned to reduce future risks.

The registered manager told us how they were developing links with the community. This included working with the local hospice. They were also building links with local pre-school and choir. Once a month the service held a community coffee morning. Christmas 2017 people in the community, who may be alone, were offered to attend the service for Christmas lunch, with transport provided where needed. Of the people who had attended, some had made friends and some had moved into the service.