Dove Care Homes Limited

Emmanuel Care Home

Inspection report

17 Southfield
Hessle
Hull
Humberside
HU13 0EL

Tel: 01482649749

Date of inspection visit:
18 January 2017
19 January 2017

Date of publication:
10 March 2017

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 inspection of Emmanuel Care Home took place on 18 January 2017 and was unannounced. At the last inspection on 30 September 2015 the service met all but one of the regulations we assessed under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that inspection the service was rated 'Requires Improvement' because the registered provider was in breach of Regulation 15: Premises and equipment. This was because the registered provider had not ensured the premises were adequately maintained or cleaned. We also made three recommendations for the registered provider to address regarding the dining experience, activities and quality assurance.

Emmanuel Care Home is registered to provide accommodation for persons who require nursing or personal care for a maximum of 37 people. The conditions of registration were recently changed by the registered provider when the service stopped providing nursing care. As a result the service now provides care for older people and people living with dementia, but does not provide nursing care. There were 28 people using the service at the time of this inspection.

The service is situated in a quiet residential area of Hessle on the outskirts of the city of Kingston-Upon-Hull and consists of a large traditional house with a modern extension to the rear of the property. There is a car park on site for visitors. All bedrooms are now used for single occupancy and some have en-suite toilet facilities.

The registered provider was required to have a registered manager in post. On the day of the inspection there was a manager that had been in post for the last six months. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had recently been interviewed following their application to become the registered manager and was awaiting the outcome.

At this inspection the registered provider had made sufficient improvements to show they were no longer in breach of any of the regulations and had met the recommendations we made. The premises were safely maintained and there was evidence in the form of maintenance certificates, contracts and records to show this. Refurbishments had taken place and an on-going programme of maintenance continued so that eventually all of the premises would be upgraded and redecorated.

The dining experience had improved for people and they received adequate nutrition and hydration to maintain their health and wellbeing.

A new activities coordinator was now employed and people had the opportunity to engage in some pastimes and activities if they wished to in order to pass the time of day. Activities were usually designed to stimulate the brain, keep skills going and stretch the imagination.

There was an effective system in place for checking the quality of the service using audits, satisfaction surveys, meetings and good communication. Improvements in systems were made to ensure they effectively checked people's experience of the care they received and relatives were satisfied with the quality of care provided.

People were protected from the risk of harm because the registered provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Staff were appropriately trained in safeguarding adults from abuse and understood their responsibilities in respect of managing potential and actual safeguarding concerns. Risks were managed and reduced on an individual and group basis so that people avoided injury, harm or abuse.

Staffing numbers were sufficient to meet people's needs and we saw that rosters accurately reflected the staff that were on duty. Recruitment policies, procedures and practices were carefully followed to ensure staff were suitable to care for vulnerable people. The management of medicines was safely carried out and infection control practices were safe.

People were cared for and supported by qualified and competent staff that were regularly supervised and appraised regarding their personal performance. People's mental capacity was appropriately assessed and their rights were protected. Staff had knowledge and understanding of their roles and responsibilities in respect of the Mental Capacity Act (MCA) 2005 and they understood the importance of people being supported to make decisions for themselves. The registered manager ensured legislation was appropriately used to reach decisions made in people's best interests where they lacked capacity.

The premises were suitable for providing care to older people and those living with dementia. We were told that additional work was planned to further improve the environment (provide activities and occupation) so that it was entirely suitable to meet the needs of those living with dementia.

We found that people received compassionate care from kind staff. People were supplied with information relevant to their needs, were involved in all aspects of their care and were always asked for their consent before staff undertook care and support tasks.

People's wellbeing, privacy, dignity and independence were monitored and respected. This ensured people were satisfied and enabled to take control of their lives.

People were supported according to their person-centred care plans, which were regularly reviewed. People had very good family connections and support networks.

There was an effective complaint procedure in place and people had complaints investigated without bias. People that used the service, relatives and their friends were encouraged to maintain healthy relationships through frequent visits, telephone calls and sharing of information.

The service was well-led and people had the benefit of a culture and management style that was positive and inclusive.

People had opportunities to make their views known through formal complaint and quality monitoring formats. People were assured that recording systems used in the service protected their privacy and confidentiality, as records were well maintained and were held securely in the premises.

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.

People were protected from the risk of harm because the registered provider had systems in place to detect, monitor and report potential or actual safeguarding concerns. Risks were managed and reduced so that people avoided injury or harm.

The premises were safely maintained, staffing numbers were sufficient to meet people's need and recruitment practices were carefully followed. People's medication was safely managed and infection control standards were maintained.

Is the service effective?

Good

The service was effective.

People were cared for and supported by qualified and competent staff that were regularly supervised and had their performance annually appraised. Communication was effective, people's mental capacity was appropriately assessed and their rights were protected.

People received adequate nutrition and hydration to maintain their health and wellbeing. The premises were suitable for providing care to older people and those living with dementia.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind staff. People were supplied with information relevant to their needs and were involved in all aspects of their care.

People's wellbeing, privacy, dignity and independence were monitored and respected and staff ensured these as much as possible.

Is the service responsive?

Good

The service was responsive.

People were supported according to their person-centred care plans, which were regularly reviewed. They had the opportunity to engage in pastimes and activities.

People and relatives had complaints investigated without bias. Relationships were encouraged and people were given opportunities to remain in control of their lives.

Is the service well-led?

Good

The service was well-led.

People benefited from a well-led service, where the culture and the management style were positive and inclusive. Quality assurance systems were effective and ensured people received appropriate care.

People had opportunities to make their views known and people were assured that recording systems in use protected their privacy and confidentiality. Records were well maintained and were held securely in the premises.

Emmanuel 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.

The inspection of Emmanuel Care Home took place on 18 and 19 January 2017 and was unannounced. One adult social care inspector carried out the inspection.

Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also requested feedback from local authorities that contracted services with Emmanuel Care Home. We reviewed information from people who had contacted CQC to make their views known about the service.

We received a 'provider information return' (PIR) from the registered provider. A 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.

We spoke with ten people that used the service, three relatives and the registered manager. We spoke with three staff that worked at Emmanuel Care Home. We looked at care files belonging to three people that used the service and at recruitment files and training records for four staff. We viewed records and documentation relating to systems for the running of the service, including quality assurance, management of medicines and the safety of the premises. We also looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and the staff. We looked around the premises and saw communal areas and people's bedrooms, after asking their permission to do so.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Emmanuel Care Home. They explained to us that they found staff to be "Reliable, safety aware and protective." One person said, "The staff are angels." Relatives we spoke with said, "I am happy that the staff are good people" and "I think [Name] is safe living here, or I wouldn't let them stay."

At the last inspection the registered provider was in breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not ensured carpets were in good repair and safe, outdoor equipment was unsafely stored indoors, equipment and furniture was inadequately cleaned, personal clothing was dried inappropriately, toilet and bathroom facilities were poorly maintained and dirty, and general maintenance was lacking.

At this inspection we found the registered provider had made sufficient improvement to the premises. A programme of refurbishment had taken place and the dining room, for example, was fitted with floor covering that was easily cleaned, equipped with new furniture, was newly decorated and had new light fittings. The lounge areas and some bedrooms were also refurbished.

The registered provider had maintenance safety certificates in place for utilities and equipment used in the service that were all up-to-date. These included, for example, fire systems, electrical installations, gas appliances, hot water temperature at outlets, lifting equipment and the passenger lift. The registered provider ensured there was a safe environment through regular maintenance checks.

The service had systems in place to manage safeguarding incidents and staff were trained in safeguarding people from abuse. Staff confirmed to us the training they had completed. Staff demonstrated knowledge of what constituted abuse, what the signs and symptoms of abuse might be and how to refer suspected or actual incidents.

Staff said, "Things are much better here now, for everyone, and we have good knowledge of safeguarding responsibilities" and "I have completed safeguarding training and understand all about whistle blowing as well. I would not hesitate to report anything I saw that was abusive."

There was evidence in staff training records that staff were trained in safeguarding adults from abuse and we saw the records held in respect of handling incidents and the referrals that had been made to the local authority safeguarding team. These corresponded with what we had been informed about by the service through formal notifications to us, which numbered four safeguarding referrals in the last year. All of this ensured that people who used the service were protected from the risk of harm and abuse.

Risks were appropriately managed so that people were protected from harm or injury. People had risk assessments in place to reduce their risk of harm from, for example, falls, poor positioning, moving around the premises, inadequate nutritional intake and the use of bed safety rails and walking aids. The handyperson, who was given responsibility to ensure risk assessments for equipment were in place and kept

up-to-date, ensured those in relation to equipment were overseen and reviewed. People also had personal safety documentation for evacuating them individually from the building in the event of a fire.

The handyperson also kept and reviewed risk assessments for staff, people that used the service and any visitors. These included risk assessments on working at height, use of hot water, moving furniture, administering first aid and monitoring legionella. The handyperson had a file containing best practice guidance information on the use of equipment and utilities. Strategies for safe working and risk assessments were in place to reduce risk wherever possible. All of these safety measures and checks meant that people were kept safe from the risks of harm or injury.

Accident and incident policies and records were in place should anyone living or working there have an accident or be involved in an incident. Records showed that these had been recorded thoroughly and action had been taken to treat injured persons and prevent accidents re-occurring.

When we looked at the staffing rosters and checked these against the numbers of staff on duty during our inspection we saw that they corresponded. Six care workers were on duty in the morning and three in the afternoon of the first day we visited. People and their relatives told us they thought there were enough staff to support people with their needs. Staff told us they covered shifts when necessary and found they had sufficient time to carry out their responsibilities and spend time chatting to people and assisting them with some pastimes or activities. We saw that there were sufficient staff on duty to meet people's needs.

The registered manager told us they used thorough recruitment procedures to ensure staff were right for the job. They ensured job applications were completed, references requested and Disclosure and Barring Service (DBS) checks were carried out before staff started working. A DBS check is a legal requirement for anyone applying for a job or to work voluntarily with children or vulnerable adults, which checks if they have a criminal record that would bar them from working with these people. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

In the four recruitment files we looked at we saw that evidence of identity, interview questions and answers, a contract of employment and job description were also available. The registered manager followed a protocol for recording information obtained from recruitment and maintained a record of this for each staff member. Staff had not begun to work in the service until all of their recruitment checks had been completed which meant people they cared for were protected from the risk of receiving support from staff that were unsuitable.

We looked at how medicines were managed within the service and checked a selection of medication administration record (MAR) charts. The service used a monitored dosage system with a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for the administration of measured doses given at specific times.

We saw that medicines were obtained in a timely way so that people did not run out of them, that they were stored safely, and that medicines were administered on time, recorded correctly and disposed of appropriately. Because the service had recently de-registered its regulated activities for providing nursing care, there had been a change in how unused medicines were disposed of. Staff were still getting used to the new returns system and therefore a large number of medicines were waiting to be returned to the pharmacist for destruction. This was brought to the registered manager's attention for action.

Controlled drugs held in the service (those required to be handled in a particularly safe way according to the

Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001), were safely managed. One controlled drug was over-stocked and this was brought to the senior staff member's attention for action.

The registered manager told us that people's medicines were soon (from 20 February) to be stored in their bedrooms to offer more privacy and a person-centred approach when taking their medicines. Medicine audits were completed each month to check that staff were managing medicines safely and people were protected from harmful errors when taking their medicines.

When we asked people about handling and taking their medicines they said, "I only take a couple of little ones (tablets) but the staff are always coming in to make sure I've taken them" and "Staff look after my medicines, which is fine by me, as I have lots to take." We saw a senior staff member administering medicines shortly after lunch and this was completed safely and carefully. They told us that where people wished to self-medicate and had capacity they were encouraged to do so.

The registered manager ensured there were suitable infection control measures in place to protect people from harm. The premises were clean and hygienic, staff were trained in the prevention and control of infection and they followed infection control good practice guidelines. The kitchen was regularly checked for good food hygiene and cleanliness via quarterly auditing and there were cleaning schedules for staff to follow and records held of all cleaning completed.

Good

Is the service effective?

Our findings

At the last inspection we made a recommendation to ensure people's dining experience improved.

At this inspection we found the dining room had been refurbished with new flooring, furnishings and lighting. There were tablecloths on tables and places were set with tools and condiments. The dining room had been fully refurbished: decorated, new tables and chairs and new lights fitted to the ceiling, all of which made for a modern and pleasant experience.

A senior staff member had been made a nutrition champion (someone who encourages good nutrition and checks that staff are providing people with appropriate amounts of food and fluid for their needs).

People's nutritional needs were met because people were consulted about their dietary likes and dislikes, allergies and needs due to medical conditions. The staff sought the advice of a Speech and Language Therapist (SALT) when needed. Nutritional risk assessments were in place where people had difficulty swallowing or where they needed support to eat and drink. Some staff were booked to attend training on the local authority's 'Nutrition Mission' (an award-based incentive scheme and programme to aid staff and carers in providing high quality nutrition to people they care for).

Menus were on display for people to see what was on offer and there was a choice of two options and if necessary an extra alternative was available. One person said, "The food choices today sound good and I think I have opted for the liver." We were told that 'personal place-mats' were being introduced with people's names, their nutritional needs and individual food preferences printed on them.

There were two new chefs in the service and people said the food had improved as a result, as there were several complaints about food in the few months before they arrived. The chefs and kitchen staff were aware of people's dietary needs as a result of any medical conditions and allergies.

Some people took their meals in their bedroom and we saw one person eating in the lounge. Staff had canteen trolleys on which to take people's food round to them. We saw that meals were plated and covered with protective lids for safe food hygiene when moving around the service. The dining experience for people that used the service had improved greatly.

People we spoke with felt the staff at Emmanuel Care Home understood them well and had the knowledge to care for them. One person said, "Staff are precise and knowledgeable" and "They seem to know which equipment to use and how to use it."

We saw that the registered provider had systems in place to ensure staff received the training and

experience they required to carry out their roles. A staff training record was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed. Staff confirmed the training they had completed.

Staff completed an induction programme and their performance was monitored via one-to-one supervision and the implementation of a staff appraisal scheme. Induction followed the guidelines and format of the Care Certificate (a set of standards that social care and health workers follow in their daily working life). The Care Certificate covers the new minimum standards that should be learned as part of induction training for new care workers.

The registered manager told us that there was a strong team of care workers at the service and while they were up-to-date with their training there were some skills that needed developing. New computer software was in place to assist with the induction and training of new staff and to aid existing staff with training opportunities for further development. All mandatory training (minimum training as required of staff by the registered provider to ensure their competence) was allocated to staff via this on-line training package.

The registered manager told us that staff accessed training with the local authorities in the area as well. The registered manager and one of the senior carers completed the manager's safeguarding training with East Riding of Yorkshire Council (ERYC) and another senior carer completed their medicines management training. A group of staff were booked to complete training in the management of medicines, delivered by a local pharmacy and in the principles of the Mental Capacity Act 2005, delivered by the registered manager who was an approved trainer. There were planned dates for staff to complete training on ERYC's Nutrition Mission programme.

There were two employees from a training company visiting staff for NVQ sign-up and the registered manager explained that an agreement was reached to look at holding trainee/assessor meetings with staff out of their working hours in future. This was to ensure there was no encroachment of the time spent on meeting people's needs.

Communication within the service was effective between the management team, the staff, people that used the service and their relatives. Methods used included a communication book which passed information to staff on people's needs and demeanours. Daily diary notes, memos placed on the staff work station in the dining room, meetings, notices and face-to-face conversations were also used. We saw people and visitors asking for support and information from staff, which indicated that communications were good.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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. There were two people with DoLS in place that were soon to be reviewed and a third person had an application awaiting approval. Some staff were aware of the MCA requirements and principles and understood the implications of DoLS.

Seeking consent from people to care for and support them was obtained by staff before providing any help to them. People either verbally agreed or conformed with staff requests to accompany them. People accepted the support they were offered. Some documents in people's files had been signed by people or their relatives to give permission for photographs to be taken, care plans to be implemented or medication to be handled on their behalf, for example.

We saw that people's health care needs were met because people were consulted about their medical conditions and the information was collated and reviewed with changes in their conditions. One person told us their health had improved greatly since coming into Emmanuel Care Home and they were no longer wishing to return home. They said, "I am treated really well. There are nice people here."

Staff told us that people could see their GP on request and the services of the District Nurse, chiropodist, dentist and optician were obtained whenever necessary. Confirmation of when people had seen health care professionals was recorded in people's files and noted the reasons why they had been visited and the outcome of the consultation. We saw that diary notes recorded where people had been assisted with the health care that had been suggested for them.

At this inspection we saw that some bathrooms were refurbished so that they included 'wet-room' facilities with sensor lighting, shower, toilet and basin. Bedrooms contained wall-mounted medicine cabinets in preparation of the planned change in medicine storage. Those bedrooms without an en-suite toilet were few, but had good facilities close by in the form of communal bathrooms with full wet-room facilities.

Upstairs there was a quiet lounge and a small kitchen facility for people and their visitors to make drinks. These changes were completed but the rooms were not yet fully operational as they needed small electrical items and coffee/milk stocks.

For those people that used the service who were living with dementia, there was adequate signage and adherence to plain carpets and decoration to enhance their quality of life by nurturing a better environment. Environment incorporates design and building layout, colour schemes, textures, experience, light, sound, smell. The registered manager was working towards having an improved environment that was suitable for people living with dementia.

Good

Is the service caring?

Our findings

People we spoke with told us they got on very well with staff and each other. They said, "The staff are very kind, otherwise I would not stay here", "Staff are friendly and look after me well", "I get on quite well with everyone, residents and staff" and "Everyone is so very kind, I cannot fault one of them."

We saw that staff had a pleasant manner when they approached people and were clearly open with their compassion and affection for people. Staff knew people's needs well. Some of the staff had been employed at Emmanuel Care Home for several years, while others were quite new. The management team led by example and were polite, attentive and informative in their approach to people that used the service and their relatives. Management and staff gave the sense that people mattered and meeting their needs was paramount.

The registered manager told us they were trying to set up a 'befriender' volunteer scheme in the local area and an advert was posted in the local church to appeal to people to come forward so they could befriend people that used the service and offer them conversation and companionship. This was still in the planning stage but if established would enable people to have different conversations with and attention from people other than staff and relatives. This would enhance people's wellbeing.

Discussion with the staff revealed those people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation, had their needs met. We were told that some people had religious needs and these were adequately provided for within people's own family and spiritual circles, or with visits from the vicar, priest or rabbi. People with physical disabilities due to age were supported to attend meals and activities when they wished. We saw no evidence to suggest that anyone that used the service was discriminated against.

The general well-being of people that used the service was considered and monitored by the staff who knew what events or incidents upset people's mental health, or their physical ability and health. People were supported to lead the lives and enjoy the pastimes they had undertaken before coming to live at Emmanuel care Home, which meant they were able to maintain control of many aspects of the lifestyle they knew. This helped people to feel their lives were worthwhile and aided their overall wellbeing. We found that people were experiencing a satisfactory level of well-being and were quite positive about their lives.

While we were told by the management team that no person living at Emmanuel Care Home was without relatives or friends to represent them, we were told that advocacy services were available if required. (Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them.) Information was provided on the resident notice board and in the 'statement of purpose'.

The registered manager told us they were aware of their responsibilities under the Accessible Information Standards and would ensure the appropriate means of providing information to anyone identified with a

particular communication need. They already supplied information in large print and on loop-system if required. They also told us that the service was registered with the Information Commissioner's Office with regard to confidential information and material being held on the computer and on the premises. People had opportunities to receive information in the format they required it and were ensured their personal details were protected from anyone accessing them that did not have cause to.

People we spoke with told us their privacy, dignity and independence were always respected by staff. People said, "I have no worries about staff being discreet" and "Staff always make sure I feel comfortable when assisting me with care." We saw that staff only provided care considered to be personal in people's bedrooms or bathrooms, knocked on bedroom doors before entering and ensured bathroom doors were closed quickly if they had to enter and exit, so that people were never seen in an undignified state. Staff gave out tabards at meal times for anyone wishing to protect their clothes from spills and so maintain their dignity.

We were told by the registered manager that all staff had signed up with Dove Care Homes Limited to be 'dignity champions' under guidance of the Dignity in Care Network led by the National Dignity Council.

Good

Is the service responsive?

Our findings

At the last inspection we made a recommendation that the registered provider ensured they provided people with activity and entertainment.

At this inspection we found improvements had been made with activities being offered and facilitated by a newly appointed activities coordinator. People told us they sometimes joined in with stretching to music and playing instruments. They said, "The new lady is very enthusiastic" and "I join in with whatever I can, as I like the company", although one person said, "If there are any activities I haven't found them, but I like to keep myself private anyway."

We saw items in place for simple pastimes, including board games, carpet games (skittles and boules) and craft work. There were magazines, newspapers and puzzle books available. People watched television in their bedrooms and listened to music in the dining room, which we asked staff to ensure was set to appropriate channels for people's preferences.

We looked at three care files for people that used the service and found that the care plans reflected the needs that people appeared to present. Care plans were person-centred and contained information under several areas of care to instruct staff on how best to meet people's individual needs. There were two formats in use because the registered manager was in the process of reviewing the documentation used. Both formats contained personal risk assessment forms to show how risk to people would be reduced, for example, with pressure relief, falls, moving and handling, nutrition and bathing.

They contained diary notes and monitoring charts, personal profiles and histories and instructions on how best to deal with specific events, such as serious illness, incapacity and death. We saw that care plans and risk assessments were reviewed monthly or as people's needs changed.

The service used hoisting equipment for assisting some people to transfer and move around the premises and it was used effectively. People were assessed for its use and there were risk assessments in place to ensure no one used it incorrectly. Other items included slide sheets and supporting belts, but these were not seen in use. The staff understood that people had their own hoist slings to avoid cross infection and these were kept in one particular store. We also saw staff assisting people to transfer without aids; those that just needed encouragement and support.

Bed rail safety equipment was in place on people's beds and these were also risk assessed for safe use. Where it was considered appropriate people were asked if they would like the use of adaptive cutlery and crockery aids so that they could maintain their independence. All equipment in place was there to aid people in their daily lives to ensure independence and effective living, but only if people wanted them and they had been risk assessed for them.

Some people preferred to remain in their bedrooms and only mix with others at meal times. These people were visited throughout the day by staff checking they didn't need anything. Some people spent time on

bed rest, rarely getting up and all of their personal care needs were met by staff going to them at regular intervals and assisting them with positional changes, drinks and food. These people had monitoring charts that recorded when staff had supported them and we saw these were completed appropriately.

Staff told us that it was important to provide people with choice whenever possible, so that people continued to make decisions for themselves and stay in control of their lives. People had a choice of main menu each day and if they changed their mind the cook usually catered for them. People chose where they sat, who with, when they rose from bed or went to bed, what they wore each day and whether or not they went out or joined in with entertainment and activities. One person said, "I sort myself out to get up. I was early today. I make my own decisions whenever I can. I watch a bit of television at night. I don't like to be bossed about, so the staff leave me alone."

The service had a complaint policy and procedure in place for everyone to follow and records showed that complaints and concerns were handled within timescales. Systems used and records held were computerised and people were supported to complete the complaint forms if necessary. Compliments were recorded in the form of letters and cards.

People told us different things about knowing how to complain. They said, "I'm not sure who to see, but I have never been unhappy about anything" and "Certainly I know how to complain. I would speak to the manager." Relatives also knew how to complain or seek resolution for concerns. One said they had spoken with the registered manager about their concerns in the recent past and these were appropriately addressed.

Staff we spoke with were aware of the complaint procedures and had a healthy approach to receiving complaints, as they understood that these helped them to get things right the next time. We saw that the service had handled four complaints in the last year and complainants had been given written details of explanations and solutions following investigation. All of this meant the service was responsive to people's needs.

Good

Is the service well-led?

Our findings

People we spoke with felt the service had a pleasant, family orientated atmosphere. Staff we spoke with said the culture of the service was, "Positive, inclusive and nurturing." They also said, "This is the best home I have worked in" and "I will live here myself in ten years' time."

At the last inspection we made a recommendation that the quality monitoring and assurance system was developed to consult people about their views and to include staff in having a say on how the service was run.

At this inspection we found there was improvement in how the quality assurance systems operated. Quality audits were completed on a regular basis and satisfaction surveys were issued to people that used the service, relatives and health care professionals. Staff were consulted about the running of the service via their supervisions sessions.

We looked at other documents relating to the registered provider's system for monitoring and quality assuring the delivery of the service.

Audits and checks were carried out daily on the safety of the environment and monthly on areas such as staffing numbers, activities for people and meeting people's care needs. Audits were also carried out, for example, on care plan documentation, fire safety systems, kitchen hygiene and medicines management.

Where information was identified that showed a shortfall in the service, an action plan was produced, action was taken to improve the situation and a record of action taken and the outcome achieved was made.

Staff meetings were used to discuss and document larger scale issues or problems that all staff needed to be aware of and take action on. Staff meetings were held to discuss issues with the running of the service: medicine or safeguarding concerns and the need to improve care standards across the service. Recent meetings had discussed staff breaks, care standards, changes in staff responsibilities and a move towards greater person-centred care and upholding people's rights.

The registered provider was required to have a registered manager in post and on the day of the inspection there was a manager in post, who had been the manager for the last six months, had recently completed the process to become registered and was awaiting the outcome. We verified their application which was submitted to the Care Quality Commission (CQC) in October 2016. The issuing of a registered manager's certificate was still pending. The manager had been managing the service for the last six months.

The registered manager and registered provider were fully aware of the need to maintain their 'duty of candour' (responsibility to be honest and to apologise for any mistake made) under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Notifications had been sent to us over the last year and so the service had fulfilled its responsibility to ensure any required notifications were notified under the Care Quality Commission (Registration) Regulations 2009.

The management style of the registered manager and senior staff team was open and approachable. Staff told us they could express concerns or ideas any time and that they felt their views were considered. Some staff told us they were still getting used to the many changes that were happening under the current registered manager (new in post six months ago), but that they were in agreement with these changes.

The service maintained links with the local community through the church, schools, colleges and visiting local stores and cafes. Relatives played an important role in helping people to keep in touch with the community by taking people out shopping or to activities. Relatives were numerous over the two days we inspected and clearly felt welcome at Emmanuel Care Home. They came and went freely and were offered refreshments.

The service had its own written visions and values and a 'statement of purpose' and 'service user guide' that it kept up-to-date (documents explaining what the service offered) contained aims and objectives of the service. Staff were aware of the values of the service and demonstrated them in their daily work. We were told that there were no affiliations or accreditation schemes adhered to.

Records held in respect of people that used the service, staff and the running of the business were in line with the requirements of regulation and we saw that they were appropriately maintained, up-to-date and securely held.