Acorn House Residential Home Limited

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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

Overall summary

The inspection was carried out on 1 April 2015 by two inspectors and an expert by experience. It was an unannounced inspection. The service provides personal care and accommodation for a maximum of 20 older people. There were 12 people living there at the time of our inspection.

No one using the service at the time of our inspection was living with dementia. People had varied communication needs and abilities. People were able to express themselves verbally.

There was a manager in post whose registration with the Care Quality Commission was in process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

Accidents and incidents were recorded and monitored to identify how the risks of re-occurrence could be reduced. There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were safe recruitment procedures in place which included the checking of references.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

People lived in a clean and well maintained environment that was suited to meeting their needs. All fire protection equipment was serviced and maintained. The building was warm and welcoming. People's own rooms were personalised to reflect their individual tastes and personalities.

Staff knew each person well and understood how to meet their support needs. Each person's needs and personal preferences had been assessed before they moved into the service and were continually reviewed.

Staff's training was renewed annually, was up to date and staff had the opportunity to receive further training specific to the needs of the people they supported. All members of care staff received regular one to one supervision sessions and were scheduled for an annual appraisal to ensure they were supporting people based on their needs and to the expected standards.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no one living at the home was currently subject to a DoLS, we found that the manager understood when an application should be made and how to submit one.

Staff sought and obtained people's consent before they helped them. One person told us, "The workers don't do anything unless I say they can".

The service provided meals that were in sufficient quantity, well balanced and met people's needs and choices. One person said, "The food is very good; we have two good cooks here". Another person told us, "The puddings are really lovely". Staff knew about and provided for people's dietary preferences and restrictions.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect. People were satisfied about how their care and treatment was delivered. One person told us, "Everyone is kind and helpful". Another said, "They are kind and very caring."

People were involved in their day to day care. People's care plans were reviewed with their participation and relatives were invited to attend the reviews and contribute.

Clear information about the service, the facilities, and how to complain was provided to people and visitors. Menus, activities programme and results of satisfaction surveys were displayed for people in a suitable format.

People were able to spend private time in quiet areas when they chose to. People's privacy was respected and people were assisted with their personal care needs in a way that respected their dignity.

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

People's individual assessments and care plans were reviewed monthly with their participation and updated when their needs changed. A person told us, "They go through my file with me and my daughter every month to make sure nothing has changed and check it is still OK with us".

Summary of findings

People chose their preferred option from a range of activities and were involved in the planning of these activities. A relative told us, "I often say to Nan, can you fit me in? It always looks as if they are enjoying themselves".

The service took account of people's complaints, comments and suggestions. People's views were sought and acted on. People's relatives were asked about their views at each review of people's care plan and when they visited the home. The manager sent bi-annual satisfaction questionnaires to people's relatives or representatives, analysed the results and acted upon them. Staff told us they felt valued under the manager's leadership.

The manager notified the Care Quality Commission of any significant events that affected people or the service. The manager kept up to date with any changes in legislation that may affect the service and carried out comprehensive audits to identify how the service could improve. They acted on the results of these audits and made necessary changes to improve the quality of the service and care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs safely.

Safe recruitment procedures were followed in practice. Medicines were administered safely.

The environment was secure and well maintained.

Good

Is the service effective?
The service was effective.

Staff were trained and had a good knowledge of each person and of how to meet their specific support needs.

The manager understood when an application for DoLS should be made and how to submit one. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable and nutritious food and drink. People were referred to healthcare professionals promptly when needed.

Good

Is the service caring?
The service was caring.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness, compassion and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

People were consulted about and involved in their care and treatment.

Good

Is the service responsive?
The service was responsive.

People's care was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when needs changed. The delivery of care was in line with people's care plans.

A range of activities based on people's needs and wishes was available.

Good

Summary of findings

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted on.

Is the service well-led?

Good

The service was well led.

There was an open and positive culture which focussed on people. The manager operated an 'open door 'policy, welcoming people and staff's suggestions for improvement.

There was a robust system of quality assurance in place. The manager carried out audits and analysed them to identify where improvements could be made and action was taken to make these improvements.

Acorn House Residential Home Limited

Detailed findings

Background to this inspection

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

This inspection was carried out on 1 April 2015 and was unannounced. The inspection team consisted of 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. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people.

The manager had not received a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during the inspection. Before our inspection we looked at records that were sent to us by the manager or the local authority to inform us of significant changes and events. We reviewed our previous inspection reports. We consulted a mental health social worker and a local authority case manager who oversaw people's care in the service. We obtained their feedback about their experience of the service.

We looked at records which included those related to people's care, staff management, staff recruitment and quality of the service. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We looked at the activities programme and the satisfaction surveys that had been carried out. We sampled eight of the services' policies and procedures.

We spoke with eight people who lived in the service and two of their relatives to gather their feedback. We also spoke with the provider, a director who was responsible for supervising the management of the regulated activity, the manager, seven members of care staff and the cook.

At our last inspections on 28 October 2014 no concerns were found.

Good

Is the service safe?

Our findings

People told us, "I am quite safe here" and "The staff and surroundings make you feel quite at home". A relative told us, "Our mother is safe, we never had any problems; Mum would certainly tell us and the staff if she wasn't happy". A member of staff said, "We have to protect the residents and make sure they are safe".

There were sufficient staff on duty to meet people's needs. People's individual needs were assessed and this information was used to calculate how many staff were needed on shift at any time. A person was moving into the home in the week following our inspection and the manager was aware that they would need to review staffing levels when increasing the number of people who lived at the home. They had completed an assessment of the person's needs to ensure the home could provide staffing that was sufficient to meet their needs. Additional staff had been provided to assist a person's recovery following a fall and a period of hospitalisation.

We reviewed the rotas and saw that they reflected the level of staffing that had been identified as necessary. The staff told us that there were sufficient numbers of staff on shift to meet people's needs. We observed the staff were not rushed and carried out their tasks in a calm manner. This ensured staff were available to respond promptly to people's needs and ensure their safety. Staff covered additional shifts in case of sickness and if required the manager also supported shifts to ensure people's needs were met. Domestic staff worked five days a week and there was no additional cover for domestic duties on weekends. However, this had been identified as an issue by the manager and it had been addressed by asking domestic staff to work more flexibly to arrange cover including at weekends.

We checked six staff files to ensure safe recruitment procedures were followed. We found that suitable checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the home until it had been established that they were suitable to work with people who may be vulnerable. Staff members had provided proof of identity, proof of address and proof of the right to work in the United Kingdom prior to starting to work at the home. References had been taken up before staff were appointed and we saw that references were obtained from the most recent employer where possible. Full employment histories had been documented. Interview notes were kept on file to document that staff had demonstrated their competence for the role at interview.

All staff received an induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. They were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Staff were trained in recognising the signs of abuse and knew how to refer to the local authority if they had any concerns. Staff training records confirmed that their training in the safeguarding of adults was annual and up to date. Staff told us about their knowledge of the procedures to follow that included contacting local safeguarding authorities and of the whistle blowing policy should they have any concerns. One member of staff said, "We have to protect the residents and make sure they are safe". They told us that they had confidence in the manager's response. A care worker said, "The manager will definitely act if I am concerned about anyone's safety".

The provider ensured that the premises were maintained safely and secure. The building was well maintained. Appropriate windows restrictors were in place to ensure people's access to windows was safe. Portable electrical appliances were serviced regularly to ensure they were safe to use. All equipment that was used to help people move had been regularly serviced. People's call bells were checked daily and regularly maintained. Bedrooms were warm, spacious and clutter-free so people could move around safely. The bathrooms were equipped with aids to ensure people's safety.

Staff were trained in first aid and fire awareness and they knew how to respond in the event of a fire to keep people as safe as possible. Fired drills were practiced regularly and recorded. There fire doors throughout the premises. All fire protection equipment was serviced and maintained. There were clear signs throughout the premises to indicate fire exits and exits were fully accessible.

The service had an appropriate business contingency plan that addressed possible emergencies. It clearly

Good

Is the service safe?

documented steps that should be taken and identified a local building that was available if it was necessary to evacuate the service. The manager and the provider were available at short notice during out of hours to respond to any emergencies.

Risk assessments were centred on the needs of the individual. Accidents and incidents were recorded and regularly monitored by staff and the manager to ensure hazards were identified and reduced. They included clear actions for the staff to take to reduce the risks. For example, a risk assessment had been carried out for a person who experienced limb weakness. The associated risk of falls and the need to have two members of staff support the person while getting dressed, undressed and while moving in the home had been identified. This additional staff support was provided for this person. The use of equipment while bathing had been identified and this was used in practice.

The people we spoke with confirmed they received their medicines on time and as prescribed. One person said, “Medicines are always given on time, regular as clockwork” and, “I have my medicine in the morning, never had any problem with it”.

People’s medicines were managed so that they received them safely. The staff followed a policy for the administration of medicines that was regularly reviewed and up to date. Staff who administered medicines were assessed to check their competency to carry out this task safely. One staff member who had recently returned from leave had undertaken additional refresher training to ensure that they were competent to administer medicines. Checks of medicines were carried out to ensure that supplies were sufficient in meeting people’s needs. All medicines including those that were prescribed ‘as required’ were kept securely and at the correct temperature to ensure that they remained fit for use. Although the temperature of the room where medicines were stored was checked and documented there was no guidance on the form concerning the maximum temperature for storing medicines. We discussed this with the manager and this was remedied. Staff followed requirements as indicated in people’s individual Medication Administration Records (MAR) and signed to evidence the medicine had been taken. The MAR sheets were completed accurately and no errors had been noted in the last 12 months. The staff we spoke with were knowledgeable about the steps that should be taken if an error was made. Regular medicines audits were carried out on a weekly and monthly basis. Two additional audits had also been carried out by the dispensing pharmacy in October 2014 and by the clinical commissioning group in March 2015. These showed that there were no concerns identified in relation to the management of medicines in the home.

Good

Is the service effective?

Our findings

People's needs were assessed, recorded and communicated to staff effectively. The staff followed specific instructions to meet individual needs. One person told us, "All the workers here are very efficient and they do what they are supposed to do, in time and with a smile". Another said, "They know me very well so they know what I need".

Specific communication methods were used by staff to converse with people. The staff communicated effectively with a person who preferred not using verbal communication. They used specific signs that the person had taught them and all staff were aware of this requirement. This guidance was included in their care plan. People's hearing aids were checked every month to ensure they remained in good order. Updates concerning people's welfare were appropriately communicated between staff at handover to ensure continuity of care.

Staff had appropriate training and experience to support people with their individual needs. Staff confirmed with us they had received a comprehensive induction and had demonstrated their competence before they had been allowed to work on their own. Newer staff worked a minimum of three shifts while shadowing more experienced staff members. This was confirmed by a staff member who had recently started working at the home.

Essential training was provided annually and was up to date, or scheduled to take place within the next two months. Staff were positive about the range of training courses available to them. One staff member described the training as 'Fantastic'. Another staff member said they had been offered a choice of online or face to face training for a refresher course. Staff told us that the training helped them to understand and meet people's needs.

Staff had the opportunity to receive further training specific to the needs of the people they supported. For example, staff were scheduled to attend a training course on diabetes awareness, and end of life care run by a local hospice. The manager was seeking opportunities to provide a wider of range of courses for staff to attend. Staff were supported to gain qualifications and study for a diploma in health and social care. One staff member told us they were being supported to enrol on a course to gain a management qualification. This meant that staff were able to develop their skills and knowledge and share good practice with the whole staff team.

One to one supervision sessions for staff were regularly carried out in accordance with the home's supervision policy. Further to staff supervisions held in March 2015, the manager had identified a need for further training concerning breathing and blood pressure observations. As a result, additional training had been arranged with the community health team. Annual appraisals were completed for staff. Staff were positive about the appraisal process and felt that they were given useful feedback. One staff member said their experience of being appraised was 'Lovely' and they had been given support to develop within their role. Staff were subject to a probation period and disciplinary procedures if they did not meet the required standards of practice. This meant the staff were clear about the expected standards and how to care effectively for people.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the Mental Capacity Act (MCA) 2005 and DoLS with the manager and they demonstrated a good understanding of the process to follow when people did not have the mental capacity required to make certain decisions. Staff were trained in the principles of the MCA and the DoLS and the five main principles of the MCA were applied in practice. This ensured people's right to make their own decisions was respected and promoted. There had been no cause for assessing people's mental capacity since our last inspection.

Staff sought and obtained people's consent before they helped them. One person told us, "The workers don't do anything unless I say they can". When people declined, for example when they did not wish to get up or go to bed, their wishes were respected and staff checked again a short while later to make sure people had not changed their mind.

We observed lunch being provided. The meal was freshly cooked, well presented and looked appetising. It was hot and in sufficient amount. Condiments were available. People were able to have second helpings if they wished. One person said, "The food is very good; we have two good cooks here". Another person told us, "The puddings are really lovely". A relative told us, "Mum loves her food; they

Good

Is the service effective?

even put on her favourite food onto the menu for her". Visitors were welcome to join their relatives at mealtimes. There was ample of amount of fresh food available in the kitchen and storage area, which was kept at correct temperature. The service held a current Food and Hygiene Certificate at the highest possible rating level of 5.

Menus were discussed with people during residents' meetings and their wishes were recorded and acted on. People's preferences and further suggestions about meals were recorded in a kitchen communication book. The cook told us, "Recently we had a request for spam fritters which they enjoyed, yesterday someone has asked for ploughman's so I will add this to the menu this week".

People chose from a selection of two main dishes and two desserts. Staff reminded people of their choice and offered an alternative if they had changed their mind. Specific dietary needs for people who had diabetes, specific food intolerance or for people who needed a soft diet were respected and provided for. The cook had supported a person who wished to become vegetarian. A person said, "I have a choice of what to eat; I am allergic to lamb so there is always another choice for me".

We observed people being offered hot drinks and a choice of cake or healthy snacks throughout the day. Easter eggs for people were especially delivered to the service on Easter Sunday and people told us they were looking forward to this. People were supported by staff with eating and drinking when they needed encouragement. We observed staff asking a person whose appetite had declined, "Did you enjoy that, you have done very well, what are you going to have for pudding today?". People were weighed monthly. Their weight was monitored and people were referred to health professionals if necessary such as when substantial changes of weight were noted.

People's wellbeing was promoted by regular visits from healthcare professionals. A G.P. visited when people's health changed and reviewed people's medicines when needed. A chiropodist visited every six weeks to provide treatment and an optician and a dentist visited when required. Vaccination against influenza was carried out when people had provided their consent. District nurses visited people regularly when they needed to provide treatments such as dressings.

People were supported with their health needs when they became unwell. A G.P had been called for a person who experienced swelling and staff accompanied them to a specialised clinic in a local hospital to undergo further tests. A person who needed antibiotic medicines and who was unable to ingest them orally was referred to a district nurse for intravenous administration. Emergency services had been called when a person was particularly unwell. On the day of our inspection, staff noticed a person's inflamed toe nail. A chiropodist was called and attended later that day to carry out a treatment. Follow-up appointments with healthcare professionals were scheduled and attended. Handovers were carried out when shifts changed and records were kept concerning information that was passed between staff members. Staff told us that handovers provided them with all of the information they needed concerning people's health. This system ensured that people's health needs were met in practice by staff who responded when people's health changed.

Good

Is the service caring?

Our findings

People told us they were satisfied with the way staff cared for them. One person told us, “Everyone is kind and helpful”. Another said, “They are kind and very caring.” One relative said, “Mum is always well presented, always looks lovely and clean, always immaculate, her clothes are always spotless and her hair is nicely done; It makes us feel good about having Mum here. Couldn’t be anywhere better”. Another relative told us, “When I am talking about my Nan I always tell people about this place. I am always recommending this home. She is well looked after”. Staff told us, “This is like a second family here”.

We spent time in the communal areas and observed how people and staff interacted. The staff displayed a polite and respectful attitude and the care that was provided was of a kind and sensitive nature. One person who has visual impairment was assisted discreetly by staff when selecting where to sit at the table. Staff spent one to one time with people if they needed company or reassurance. For example, a person had become agitated as a family member was away on holiday. The staff had comforted this person by reassuring them that their family member would be returning soon and spent time with them to provide companionship. All staff knocked on people’s bedroom doors, announced themselves and waited before entering. People chose to have their door open or closed and their privacy was respected. People were assisted with their personal care needs when needed in a way that respected their dignity. A person told us, “The staff close the door and curtains when they help me wash and dress. They are always very polite; they call me by my first name because this is what I like”.

The staff promoted independence and encouraged people to do as much as possible for themselves. People were dressing, washing and undressing themselves when they were able to do so. A person told us, “I am not a mixer and I like to have my meals served in my room and it is not a problem for the staff”. Another person had been accompanied by staff for a shopping trip using public transport and a lunch in the town. The staff told us they had “Really enjoyed the trip out”. Staff were aware of people’s history, preferences and individual needs and these were recorded in their care plans.

People were able to spend private time in quiet areas when they chose to. Some people preferred to remain in the conservatory, others chose to socialise in the lounge. A relative had commented, “It is good that there is no compulsory TV viewing in communal areas. The quieter lounge at the front of the house is appreciated by residents who wish to have privacy”.

Clear information about the service and its facilities was included in a leaflet which was available in a different format for people with visual impairment. The procedure to follow about how to complain was provided to people and visitors and displayed in the entrance. There was a notice board for people’s use that included current information about the menus, activities and events. The information was provided in a format that met people’s needs.

People were involved in their day to day care. People’s relatives were invited to participate in the reviews with people’s consent. People’s care plans were reviewed monthly to ensure they remained appropriate to people’s needs and requirements. People’s end of life wishes were recorded in their care plans when they came into the service.

Good

Is the service responsive?

Our findings

People's individual assessments of needs and their care plans were reviewed monthly with their involvement. Two people told us, "I am involved in planning my care. The staff talk to me about what I need all the time" and, "They go through my file with me and my daughter every month to make sure nothing has changed and check it is still OK with us". People confirmed staff were consistently responsive to their request for assistance. They told us, "When I press my bell they come promptly".

Each person's needs had been assessed before they moved into the service. This ensured that the staff were knowledgeable about their particular needs and wishes. People's personal records included a pre-admission assessment of their needs. Individualised care plan about each aspect of people's care had been developed and included a personal profile, their likes and dislikes, needs and relevant risk assessments. We noted that care plans contained pre-emptive recommendations. For example, "Staff to liaise with the speech and language therapist if X begins to have difficulty with her speech" and "Staff to refer to dietician if weight changes and ensure that X is aware of the reason why this referral has been made".

Care plans took into account people's history, preferences and what was important to them. For example, a person had expressed the wish to have a bath at a specific time, and had required the staff to follow a particular sequence of tasks during their morning routine. A person had listed all their wishes including how much sugar they liked in their tea and how they preferred to apply their make-up. As staff consulted people's care plans and were aware of people's preferences and life history, their wishes were respected and followed in practice. This promoted staff's understanding of people's individuality and how to respond to meet each person's care needs and wishes.

Care plans were reviewed monthly or as soon as people's needs changed and were updated to reflect these changes to ensure continuity of their care and support. For example, after a person had a fall, they had been referred to a G.P. to review their medicines and to a falls clinic. Their care plan had been updated to include guidance from a physiotherapist for staff to follow. An exercise chart was completed by staff and the person's progress and confidence when moving around were monitored.

People's bedrooms reflected their personality, preference and taste. For example, some rooms contained articles of furniture from their previous home and people were able to choose furnishings and bedding. People were offered choices and options. They had choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do. A person had expressed their wish to relocate their bedroom on a different floor and this had been implemented. The importance of respecting people's choice was emphasised at team meetings. For example the manager had reminded the staff that people were to be bathed whenever they wanted and as frequently as they wished.

Daily activities were available and were provided by staff. People were consulted when the activities were planned and their preferences and suggestions were acted upon. Monthly resident meetings were held and recorded. At the last resident meeting, people had declined specific outings and had requested activities to take place only every two days as they 'needed a quiet day in between'. However on the 'quiet day' people were still able to have one to one sessions with the staff if they wished to engage in an activity of their choice. Special requests such as 'music hall' singers had been accommodated. People told us, " They were two singers who danced and sang songs from old movies, this makes for a lovely afternoon" and, "There are plenty of activities to do here, you never get bored", and "I really enjoy 'Pat the dog' who comes every month, it reminds me of when I had my own pets". A relative told us, "I often say to Nan, can you fit me in? They have some great activities, it always looks as if they are enjoying themselves". People told us they participated in activities that included card games, armchair exercises, motivation sessions, singing and dancing, 'Bingo' and home- baking. When people did not wish to partake in activities, their wish was respected. A person said," I don't join in the activities in the afternoon, I prefer my own company. I prefer sitting out in the garden in the summer time just watching the birds". People had a television and music playing equipment in their bedrooms when they wished.

People's friends and families were welcome to visit at any time. The service held garden parties and local school children visited to sing songs to people. People's birthdays were celebrated with a party if they wished. People were accompanied by staff whenever they requested to be supported to go to town. This ensured that people's social isolation was reduced.

Good

Is the service responsive?

People's views and their relatives' views were sought and recorded at each review of their care plans and listened to. The manager sent an annual questionnaires to people's relatives or representatives and health care professionals to gather their views on the care and support provided, the activities, the food, the environment and the management of the service. All the comments were positive and showed people were satisfied with the quality of the service. Comments included, "This home has helped a lot and I am happy in this home", "Lovely"; beautiful; wonderful". A mental health social worker who oversaw a person's care in the service said, "I cannot fault this home, there has been a huge turn-around for the better, well done". A staff comment box was available for staff and visitors to use which the manager checked daily. However, this had not been used. A member of staff said, "If we have a comment to make we just talk with the manager directly; she values our opinion".

People were aware of the complaint procedures. People told us they did not have cause to complain. One person told us, "I will just speak to the staff no problem there". No complaint had been received in the last 12 months before this inspection. A relative's enquiry had been responded to by the manager and owner without delay.

Good

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people. People and members of staff were welcome to come into the office to speak with the manager at any time. The staff we spoke with were positive about the support they received from the manager, the provider and the director. One staff member described the manager as 'Brilliant' and 'Spot on'. All of the staff spoken with told us that the director checked on them regularly and offered help if required. A staff member told us they were 'Always available' if additional support was needed. Staff told us they could raise concerns and they felt they would be listened to if they did. People told us they found the owner, the director, and the manager "Very approachable". They told us, "You can talk to them; I talk to them"; "The manager is really nice, she talks with us not at us and she is genuinely interested in what I have to say" and, "She [the manager] knows her stuff, she inspires confidence". A local authority case manager who oversaw a person's care in the home told us, "This place has really improved especially with this manager on board, she obviously had a great influence on her staff".

The manager spoke to us about their philosophy of care for the service. They said, "Everyone has the right to be independent, to have their care needs assessed and met, to have their choices and dignity respected. We have a responsibility to make this place their home. This home could become a flagship for residential care and lead the way if it continues to improve". From what people, their relatives and the staff told us and from our observations, the staff knew about the aims of the home. They took action to make sure these were used in practice.

Recorded senior staff and management meetings, as well as overall staff meetings, were held every six weeks to discuss the running of the service. Staff contributed to the agenda and were able to speak freely. Records of these meetings showed that staff were reminded of particular tasks and of the standards of practice they were expected to uphold. When an action had been identified and scheduled, the manager monitored the progress of the action until it had been completed. For example the need for the removal of any distraction during handovers had been identified. As a result, a 'no entry' sign had been introduced and displayed when handovers were in progress.

The manager regularly researched relevant websites that included 'Skills for Care' and the 'National Institute of Clinical Excellence' to obtain updates on legislation and useful guidance relevant to the management of the service. The manager had discussed implications of new legislation with staff and had explained how this impacted on their practice.

All the policies that we saw were appropriate for the type of service, reviewed annually, up to date with legislation and fully accessible to staff. The manager carried out regular audits to monitor the quality of the service and identify how the service could improve. Weekly and monthly medicines audits had highlighted the need for an improvement in recording staff's signature and this had been implemented. There were monthly audits of infection control, incidents and accidents, staffing levels, complaints, staff training and environment. Monthly audits of people's files ensured that records kept were accurate, reviewed and updated appropriately, completed and fit for purpose. The manager did a daily 'walk around' and recorded any maintenance issues. This had led to a replacement of floorings and carpet, the purchase of new chairs and the refurbishing of a sluice room. Audits of satisfaction surveys were carried out twice yearly and any suggestions that had been made by people had been implemented, for example when they requested a specific activity or when a person had wished to have their bedroom relocated. The manager had audited the surveys and had displayed the result for people to see, in a simplified format to help their understanding.

The manager consistently notified the Care Quality Commission of any significant events that affected people or the service. Records indicated the manager took part in safeguarding meetings with the local authority when appropriate to discuss how to keep people safe, and kept people's families involved in decisions concerning their family members' safety and welfare.

There was a continuous improvement plan in place that outlined the goals that were set to be reached in 2015. These included improvement and upgrade of the premises and furniture, staff additional training and the designation of staff to take the lead in dignity and infection control. The manager told us, "We are on a roll with a good team and we

Good

Is the service well-led?

need to sustain the improvements that have been made". The owner confirmed that they shared this view and told us, "We will make sure the resources are made available to ensure positive improvement continues to be made".