Monarch KM Ltd

Downsvale Nursing Home

Inspection report

6-8 Pixham Lane
Dorking
Surrey
RH4 1PT

Tel: 01306887652
Website: www.downsvale.co.uk

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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

Downsvale Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Downsvale Nursing Home is registered to provide accommodation for persons who require nursing or personal care for up to 35 people and personal care. There were 26 people living at the service at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered 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 registered manager was at the home during the time of our inspection.

We last carried out a comprehensive inspection of Downsvale Nursing Home in December 2016 where we found the registered provider was in breach of 3 regulations. These related to activities, mental capacity assessments and quality assurance. Following this inspection the registered provider sent us an action plan of how they would address these issues.

The inspection took place on 26 April 2018 and was unannounced. During this inspection we found that the concerns raised at our previous inspection had been addressed.

Accidents and incidents were recorded and an analysis of why accidents or incidents had occurred or what action could be taken to prevent further accidents had been developed. There were enough staff to meet the needs of the people and for people to take part in meaningful activities. Robust recruitment procedures were completed to ensure staff were safe to work at the service. People felt safe living at the home. Staff understood their responsibilities around protecting people from harm. The provider had identified risks to people's health and safety with them, and put guidelines in place for staff to minimise the risk. Infection control processes were in place that helped to reduce the risk of infection. People received their medicines as prescribed by their GP.

Staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that decisions were made in the least restrictive way. Where there were restrictions in place, staff had followed the legal requirements to make sure that this was done in the person's best interest. People's nutritional needs were assessed and individual dietary needs were met. People had involvement from external healthcare professionals and staff supported them to remain healthy. Staff received appropriate training and had opportunities to meet with their line manager regularly that helped them to provide effective care to people. The environment was suitable for people living with dementia.

People's care and support was delivered in line with their care plans. People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual

needs and how to meet them. People were supported with their religious beliefs and were able to practice their faith.

Documentation that enabled staff to support people and to record the care they had received was up to date and reviewed on a regular basis. People would receive end of life care that was in line with their needs and preferences and staff had received training in regard to this. Care plans included people's requests about their end of life wishes that included if they wanted to remain at the home or be admitted to hospital.

Complaints were addressed within the stated timescales to the satisfaction of complainants. A complaints procedure was available to people, relatives and visitors.

The provider and staff undertook quality assurance audits to monitor the standard of service provided to people. An action plan had been produced and followed for any issues identified. People, their relatives and other associated professionals had been asked for their views about the home through surveys and resident and relatives meetings.

The interruption to people's care in the case of an emergency would be minimised. The provider had a Business Continuity Plan that provided details of how staff would manage the home in the event of adverse incidents such as fire, flood or loss of gas or electricity.

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.

Staff were knowledgeable about the process to be followed if they suspected or witnessed abuse.

There was sufficient staff deployed at the home to meet people's needs.

Risks to individual people had been identified and written guidance for staff about how to manage risks was being followed.

People were kept free from infection because staff understood the infection control processes to prevent cross infection.

Accidents and incidents were recorded and monitored to help minimise the risk of repeated events.

The provider had carried out full recruitment checks to ensure staff were safe to work at the service.

People's medicines were managed, stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and had opportunities to meet with their line manager regularly.

Where people's liberty was restricted or they were unable to make decisions for themselves, staff had followed legal guidance.

People's nutritional needs were assessed and individual dietary needs were met.

People had involvement from external healthcare professionals and staff supported them to remain healthy.

The environment was clean and suitable for people living with dementia.

Is the service caring?

Good

The service was caring.

People's care and support was delivered in line with their care plans.

People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them.

People were supported with their religious beliefs and were able to practice their faith.

Is the service responsive?

Good

The service was responsive.

Where people's needs changed staff ensured they received the correct level of support.

Activities were appropriate to the needs of people.

Information about how to make a complaint was available.

People's end of life care was provided sensitively and in line with people's needs and preferences.

Is the service well-led?

Good

The service was well-led.

People and their relatives had opportunities to give their views about the service.

Staff felt well supported by the manager.

The provider had implemented effective systems of quality monitoring and auditing.

Downsvale Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 April 2018 and was unannounced.

The inspection was carried out by two inspectors, a specialist advisor in nursing care and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with six people, two relatives and five staff members. We spoke with the registered manager and the nurse in charge. We looked at the care plans for seven people, medicines records, accidents and incidents, complaints and safeguarding. We looked at mental capacity assessments and applications to deprive people of their liberty. We reviewed audits, surveys and looked at evidence of activities taking place at the home.

We looked at four staff recruitment files and records of staff training and supervision, appraisals, a selection of policies and procedures and health and safety audits. We also looked at minutes of staff meetings and evidence of partnership working.

Good

Is the service safe?

Our findings

People were safe living at Downsvale Nursing Home. People told us that they felt safe at the home and this was reaffirmed by relatives on the day. One person told us, "I should think so, I've been here nearly two years, they're alright, and they're a good crowd." Another person told us, "I feel as safe as one might expect to with limited mobility." Relatives told us that they felt their family members were safe. One relative told us, "Seems to be safe, yes, my [family member] been here nearly 14 to 15 months." Another relative told us," Yes, I feel [family member] is safe here."

People continued to be protected from abuse because staff understood their roles in keeping people safe. The provider told us in their PIR that all staff had training in regard to keeping people safe and this is also covered during their induction. We found this to be the case. Members of staff we spoke with told us they had undertaken adult safeguarding training and this was confirmed by training records. Staff understood the correct safeguarding procedures to follow should they suspect or witness abuse. They were aware that a referral to an agency, such as the local authority safeguarding team should be made, in line with the provider's policy. One staff member told us, "I would always let the manager know if there was a problem. I know they would deal with it." The provider had worked with the local safeguarding authority to address four safeguarding concerns during the last 12 months.

People were protected from unsuitable staff because safe recruitment practices were followed before new staff were employed. We noted checks had been undertaken with the Disclosure and Barring Service (DBS). The DBS helps providers ensure only suitable people are employed in health and social care services. This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation including professional and character references, immigration status and evidence of up to date professional registration for nurses in staff files. We noted from examining staff interview notes that applicants were asked questions in areas relevant to their roles, for example, safeguarding adults.

People were kept as safe as possible because potential risks had been identified and assessed. Each person had risk assessments in place to help them maintain their independence. The provider told us in their PIR that risk assessments would be put in place for identified risks to people and we found this to be the case. People's care records contained risk assessments that included Waterlow (skin integrity), falls, bed rails, moving and handling, Malnutrition Universal Screening Tool (MUST) and nutrition. Guidance was provided to staff in regard to managing the risk. For example, one person had a catheter in place. The risk assessment and care plan regarding this was person centred and highly detailed. They contained information concerning the possible long term effects of catheterisation, such as infection and possible kidney problems and how best to prevent them. People told us that staff explained risks to them. One person told us, "I need assistance and they're very good explaining why I have to wait for help."

Each person had a personal emergency evacuation plan (PEEPs) in place. These provided guidance to staff how to safely evacuate individual people from the building in the case of an emergency. Staff were knowledgeable about the PEEPs and where they were stored. The provider also had an emergency

contingency plan that provided the contact details of utility groups, social services, the provider and places where people could be accommodated if it was not possible to re-enter and use the home.

People were supported by sufficient numbers of staff with the right skills and knowledge to meet their individual needs. People and their relatives told us that there were enough staff employed at the home. One person told us, "Yeah, there is always plenty of staff. Just ring that bell and they're here in no time." People told us that their care was never rushed by staff. One person told us, "No they take their time, they spend a reasonable amount of time with you." Another person told us, "No, [not rushed] they take their time, they're very thorough."

The registered manager told as that the numbers of staff to people were determined through the use of a dependency tool. We were told by the registered manager that there was a minimum of two nurses (RNs) on duty in the mornings with five care staff and one care staff for a resident needing one-to-one care. One nurse, four care staff 1 care staff for a resident needing one-to-one care. in the afternoons. Night duties were covered by one nurse and three care staff 1 care staff for a resident needing one-to-one care. for 26 people. The viewing of four week duty rota and discussions with staff confirmed what we were told. Staff told us that they believed there were enough staff to meet the daily needs of people.

Medicines were administered, recorded and stored safely. People told us that they usually received their medicines on time and they knew what their medicines were for. One person told us, "Basically [I get them on time]. She's [the RN] has just been in, a little later than usual but nothing untoward. By the end of the day I've been given all I need." Another person told us, "I get it every evening; I don't think it's an issue with me." One person told us that they knew what their medicines were for, they stated, "Yes. Most is for my blood pressure and other things they all have a special purpose and they all work. I've been on them for years." A relative told us, "Yes she [family member] only has two pills, one in the morning, one at six. They're time of day dependent, not hourly dependent."

The provider told us in their PIR that medicines were stored and disposed of safely and qualified staff administered medicines in line with current regulations. We found this to be the case. We observed staff administered medicines safely to people, following the guidance as recorded on the medicine administration records (MARs). Medication was stored in locked cupboards and fridges and the temperatures of these were monitored and recorded daily. Medicines were kept secure in locked medicine trolleys that were clean, tidy and well organised. All medicines were in date. Staff able to demonstrated safe dispensing and administration of prescribed medications and had knowledge of medication ordering.

We noted that the morning medicine round on the day of our inspection was not completed until 11:00am and the next round commenced at 12 noon. We discussed this with the registered manager who told us that this was not the normal timings of the medicine rounds. There was no evidence to suggest that people had not receiving their medicines. Since our inspection the registered manager had made improvements to the morning medicine round. Two RNs now administer the morning medicines. This was monitored for a week and the round now takes an average time of 44 minutes.

Monthly audits of medicines were undertaken and an action plan to address any issues identified had been implemented. For example, it was noted that one bottle of liquid medicine had not had the date it was opened recorded. This was amended and discussed with the RNs during their team meeting.

People were protected against the spread of infection within the service. Staff maintained appropriate standards of hygiene which protected people from the risk of infection. The home was cleaned regularly to maintain hygiene and reduce the risk of infection. Staff followed good practice in infection control and used

personal protective equipment, such as gloves and aprons, when providing personal care. The provider had infection control procedures for staff to follow and carried out regular audits to check appropriate standards of infection control were being maintained.

There was evidence of learning when adverse events occurred. Accidents and incidents were recorded in detail and had been reviewed by the manager to identify any measures that could reduce the risk of a recurrence. The registered manager told us that lessons are learned from accidents and incidents. For example, one person kept getting out of bed during the night without staff knowledge even though they had an alarmed pressure mat. The registered manager investigated this and found that the person had located the switch for this and turned it off. This was rectified that prevented a repeat of this.

There was up to date documentation related to the safety and suitability of the premises. These included electrical installation condition report, gas safety certificate, PAT testing, monthly hot water safety testing, Legionella Risk assessment and hoist and wheelchair servicing and maintenance.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides 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).

At our previous inspection in December 2017, we found a breach of Regulation 11 regarding the Mental Capacity Act 2005 (MCA). Consent to care had not always been obtained in line with the MCA. Furthermore, capacity assessments and best interest meetings were not always completed. The provider submitted an action plan to state they had met the legal requirements and we saw that this had been completed. During this inspection we found that the required improvements had been made.

Staff were knowledgeable about issues of consent and had a good understanding of the Mental Capacity Act (MCA) (2005). Staff told us they had undertaken recent training in this area and the training records provided to us confirmed this. Staff were aware of the implications of Act and of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. Staff told us that they always asked for people's permission before they did anything for them. One member of staff told us, "I always ask them (people) for their permission before anything is done, it is their choice to accept help or to do things on their own if they wished to." People told us that staff wouldn't do anything without asking them first. One person told us, "They ask you; do you mind." Another person told us, "Yes I would say so (ask for my permission). They don't make decisions without your approval."

People's needs and choices were assessed and care, treatment and support was delivered in line with the pre-admission assessment. People and their relatives told us that they had an assessment undertaken before they came to the home. They told us that their care and treatment was delivered as per their care plan. One person told us, "Yes I was involved in my assessment." Relatives told us that they were asked and kept informed about their family member's care and support. One relative told us," They have a monthly resident of the day, where they address their care plan. It is discussed with the relatives as well as with our family members."

People received effective care from staff who had the skills, knowledge and understanding needed to carry out their roles. The provider told us in their PIR that all staff undertake mandatory training and have an induction when they commence their roles. We found this to be the case. People told us that they believed all staff had been trained to do their jobs. One person told us, "They're all qualified they all know what they're doing." Another person said, "Yes I think so."

Staff were provided with training and had the skills, knowledge and experience to work with people including those living with dementia. The staff had worked at the home for some time which does well for continuity and familiarity for people. Staff told us that they had undertaken all the mandatory training that included moving and handling, fire, first aid, infection control and health and safety. They also told us that they received other training, such as dementia, communication, challenging behaviour, nutrition and diet and end of life care. The training programme provided to us confirmed that staff had received this training and dates for refresher training had been planned ahead. Staff were able to inform us what they had learned from their training. For example, one member of staff told us that they had learned how to use distraction techniques for people whose behaviours challenged staff.

People were supported by staff who had regular supervisions (one-to-ones) with their line manager. Staff told us that they received regular supervision. Staff told us that they discuss their roles, the people they worked with and identified their training needs. Records of supervisions and appraisals confirmed this had taken place.

People were supported to ensure they had enough to eat and drink to keep them healthy. People and their relatives were complimentary about the food provided. One person told us, "Its high class [the food], there is a family feel about it." Another person told us, "You get three meals a day, a choice of two or three options at each meal." A third person stated, "Too good. I mean it, too good." A relative told us, "[Family member] enjoys the food. The last time I was here they had soup, sandwiches and cake."

The lunch time was an enjoyable experience for people. Staff were available to provide support to people who required it. Many people chose to eat in their own bedrooms and received their meals in a timely manner. We observed pureed food was presented using different colours for the vegetables and meat; this made it easier for people living with dementia to identify foods and eat independently. Staff who supported people with their meals were patient as always asked if they were ready before presenting them with their food. Other people were encouraged to eat independently. For example, one member of staff spoke to one person saying, "I will cut your food how you like and then you can try to eat it by yourself." This person then fed themselves independently. The staff we spoke with were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet.

The cook had a list of people's dietary needs that included likes, dislikes, and special dietary needs for example, cultural beliefs, diabetic and pureed food. Allergies were also recorded in the kitchen. The cook told us that they had regular visits from a dietitian who provided advice about the menu and foods, the last visit was prior to our visit.

Nutrition and fluid charts were implemented when people were identified as being at risk of dehydration or malnutrition. For example, daily records were maintained in people's care plans that recorded the amount of fluid offered and the amount the person drank. Where this was a concern then appointments were made with the associated healthcare professionals. We observed that staff had set up hydration stations throughout the home that encouraged people to have a drink of their choice.

The staff at the home worked as a team with each other, the registered manager and the provider's quality operations manager to ensure that people received effective care. Regular meetings took place to address any issues identified to continually improve the service provided.

People had access to all healthcare professionals that supported them to live healthier lives. Care records demonstrated that people's healthcare needs were monitored by staff and that people were supported to

obtain treatment if they needed it. For example, we noted one person was an insulin dependent diabetic. There was evidence of good care day to day, such as referrals to podiatry for foot care and regular eye checks to help maintain their health. The person had blood glucose levels taken and recorded appropriately. There was guidance in the care plan to aid staff in the management of possible emergencies. For example, the care plan described the symptoms and management of hypoglycaemia and hyperglycaemia. The staff we spoke with understood their responsibilities in this area. People also had access to the GP, dentist, physiotherapy, dietitians, tissue viability nurse and opticians.

People lived in an environment that that was adapted to meet their needs. The home was divided into two buildings but was accessible via corridors on both floors. There was a lift to allow people to move around the home with ease. The flooring had recently been replaced with plain coloured carpets. The provider had an improvement plan that includes a small extension to the rear of the property and a total refurbishment of the home. The registered manager told us that these would be discussed with people so they could be included in the choice of colours for their bedrooms and the communal parts of the home. People had their personal belongings in their bedrooms. Equipment used at the home had been serviced in line with the manufacturers' recommendations.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People and their relatives told us that all members of staff at the home were kind and caring. One person told us, "They [staff] are dedicated, on time, no skiving and amicable. They're a good crowd, right from the top down." Another person said about staff, "Oh they're very good." A relative told us, "They [staff] are kind and caring."

We observed staff interacting with people in a kind and courteous manner. Staff were engaging in conversations with people throughout the day responding to people's questions. When staff supported people with their care they did this in a respectful manner and told the people what was and happening and why. For example, one person was being moved from their bedroom to a chair in the lounge. Staff spoke the person and reassured them throughout the whole process. This was undertaken by two members of staff. They spoke to the person giving them reassurance gently saying, "we are just going to lower you into your chair now."

We observed people were treated with kindness, dignity and compassion while they received care and treatment. For example, one RN closed the window in the room of a person who appeared to be feeling cold as well as making an attempt to find out if the persons were in pain so that they could be offered the required prescribed pain relief.

People were supported to express their views about their care and treatment and make decisions about their care plans. People told us they had been involved in making decisions about their care, support and treatment. One person told us, "We have talked about how I would be treated if I had a very bad episode and needed resuscitation. I said I don't want any more medication, we've agreed on that." People told us that staff explained things about your care in a way you can understand."

People's dignity was respected by staff. People told us that staff respected them as people and they respected their privacy and dignity. One person told us, "Yes they make sure they respect my privacy. They're very good." Another person told us, "Things are done with consideration." Staff told us that they respected people's privacy through knocking on doors and undertaking personal care in the privacy of people's bedrooms with the doors and curtains closed. We observed this practice throughout our visit. One member of staff told us, "We always greet people by the names they want to be called, for example 'good morning X.' We never walk into bedrooms without knocking on the doors and waiting for a response. Whenever I wash a person I make sure that any exposed parts of the body are covered."

Staff told that they encouraged people to be as independent as they were able. For example, one member of staff told us that they encouraged people to wash themselves, but they would always be available to provide support when needed. Another member of staff told us that people choose the clothes they want to wear, the meals they want to eat and the activities they wish to take part in. People told us that they were able to keep their independence. One person told us, "Oh yes, if I want to go out they don't stop me." Another person told us, "Yes, occasionally, they obviously know my limitations, But they encourage you to do things for yourself." One person's care plan informed that the person would like to maintain their freedom of

movement. Clear guidance was provided in the care plan about how to keep the environment free from hazards and how staff should offer support that ensured the person was able to move about the home.

People received care and support from staff who had got to know them well. We observed care and support provided to people throughout the day. There was a high level of engagement between people and staff and no incidents of infantilising or discourteous staff actions. Staff were responsive to people's needs and addressed them promptly and courteously. It was evident all staff knew all people really well; for example, staff knew people's food preferences without referring to documentation. People told us that staff knew about them. One person told us, "On the whole yes, they know me well."

People's religious and cultural needs were met by staff. People were able to practice their faith. Monthly visits from different religious leaders took place at the home so people could attend a service. One person's food requirement in regard to their cultural needs was respected by staff at the home.

The manager told us that no person living at the home was from the lesbian, gay, bisexual or transgender (LGBT) communities. They told us that this was explored during the pre-admission assessment so people could inform them. The manager and staff told us that they treated all people as individuals and respected their individuality.

Good

Is the service responsive?

Our findings

At our previous inspection in December 2017, we found a breach of Regulation 9 regarding the lack of a range of activities provided to people. The provider told us in their action plan that they had completed this action. People had a range of activities they could take part in. People told us that there were enough different activities that they could take part in. One person told us, "Oh yes of course there are activities. We do snakes and ladders, making decorations for the windows, making flowers." Another person told us, "You know certain things go on if you want and you can get involved if you want. They [staff] give leaflets and tell you what activities there are. There's always the opportunity to take part in them."

The provider told us in their PIR that they had invested in an activity programme that was responsive to the needs of people and that the activities took into account the needs of people with dementia. We found this to be the case. Two activity coordinators provided daily activities to people. We spoke to one activity coordinator who had excellent knowledge of each person and their hobbies and interests. They told us that they discussed the activities with people every week and a timetable is drawn up and split into three sections for each day. Some people preferred to stay in their bedrooms and an activity coordinator would go and talk to them and undertake activities on a one to one basis if they wanted this. We observed this on the day of our inspection. People were provided with the opportunity to say if they wanted to do a certain activity, asked what they like and want to do. These were then incorporated into the activity programme. For example, one person told us that they enjoyed playing board games and we saw that board games were incorporated in the activities provided. We observed this person playing scrabble with other people.

Activities included exercises, making of memory boxes, craft, crosswords, quiz, stories, reminiscence, external entertainers and music. Trips outside of the home had also been arranged and included trips to a museum and theatres to see, for example, a ballet performance. Themed activities were also provided and photographs of these were displayed in a folder at the home. For example, people had celebrated the different cultures such as Burns night, St Patrick's day and a Brazilian day. A 'Bollywood Dance' workshop had been arranged for people where they could take part in the dancing and try a selection of Indian foods.

People received care that was personalised to their needs. People and their relatives confirmed that they had been involved with their care plans and were involved in reviewing their care. One person told us, "Yes, they suggest things about my care and ask me questions, it is then up to me really." Another person told us, "My care plan was discussed with my sister and brother in law." One relative told us, "Yes I was involved with [family member] care plan." People told us that they had been asked for ideas and suggestions about their on-going care and support.

Care plans and care was person centred. Care plans were recorded on electronic systems that enabled staff to easily access information. Detailed information was recorded in care plans that included information in regard to communication, continence, medication, mobility, nutrition and hydration and personal care needs. We noted personal and social histories were very detailed; it was possible to 'see the person' in care plans. The staff we spoke with were knowledgeable about the people they were caring for. Clear guidance was provided in the care plans for staff. For example, one person lived with Parkinson's disease. Their care

plan contained up to date and relevant information about how this affected the person and what staff input was required to provide safe and effective care. Another person was an insulin dependent diabetic. We noted evidence of good care day to day, such as referrals to podiatry for foot care and regular eye checks to maintain health was recorded in their care plan. The person had blood glucose levels taken and recorded appropriately. There was guidance in the care plan to aid staff in the management of possible emergencies. For example, the care plan described the symptoms and management of hypoglycaemia and hyperglycaemia. The staff we spoke with understood their responsibilities in this area.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The provider told us in their PIR that they had received fourteen complaints during the last twelve months, all of which were resolved within the 28 day timescales as stated in their complaints policy. We found this to be the case. The most common complaints were around food choices and the management of laundry. We noted each complaint was investigated and resolved in line with the provider's policy. Complaints were also subject to monthly audits to identify trends, to ensure consistency and the rapid resolution of issues.

People and their relatives told us they knew how to make a complaint and they would feel comfortable doing this. One person told us, "Yes I have made a complaint and yes it was dealt with." Another person told us, "It's a family firm so yes." (Meaning they would feel confident to make a complaint). A relative told us they had made a complaint and it was dealt with to their satisfaction.

There was a complaints procedure available to view in the communal areas of the home. It contained information about how and to whom formal complaints should be made. There were also contact details for external agencies, such as the Local Government Ombudsman (LGO). Staff were clear about their responsibilities in the management of complaints. They told us that they would inform the registered manager about any complaints.

The registered manager and staff had received a large number of compliments in the same time period, in the form of cards and letters thanking them for the care and attention they had provided to people. For example, "Thank you so much for the kindness and care you provided to [family member] over the past few years. [Family member] could not have had better care."

End of life care was provided sensitively and in line with people's needs and preferences. Care plans included people's requests about their end of life wishes that included if they wanted to remain at the home or be admitted to hospital. End of life care plans also included body re-positioning and how to provide appropriate mouth care. This includes keeping lips moist and clean. Anticipatory drugs were requested when required. Staff worked closely with the local hospices to ensure that people had a pain free and dignified end of life care and staff had received training in this. Staff told us that they would also provide emotional support to families and that counselling could be arranged if required.

Good

Is the service well-led?

Our findings

At our previous inspection in December 2017, we found a breach of Regulation 17 in regard to records. Care plans were generic as opposed to being individualised to each person and records were not stored securely. The provider told us in their action plan that this had been completed and we found this to be the case. The provider used an electronic system for care planning. We noted that each care plan we looked at was individualised and person centred. Care plans were only assessable to staff who were provided with individual codes to access the electronic system.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and staff benefitted from a registered manager who was committed to working with people and improving the service. People, relatives and staff were complimentary about the registered manager and how well led the home was. One person told us, "I would say so yes, it is well managed." Another person told us, "They're [registered manager] professional and they communicate well." A relative told us, "Yes, I think it is well managed. I have regular contact with the owner." Staff told us they thought the home was well-led. One staff member told us, "Yes, I would say so. The manager is great and very supportive." Another staff member said, "The manager is on the floor a lot and is always available."

The provider had a set of values that included providing dignity, choice, privacy and independence. Throughout our inspection we observed staff working with people that incorporated these values in their work. For example, staff offered people choices about the food they wished to eat clothes they wanted to wear and activities they wished to partake in.

The provider promoted a positive culture. There was a staffing hierarchy at the home and all staff knew what their individual roles were and the duties they were to perform. Regular staff meetings took place where staff were able to discuss people's needs to ensure they were provided with care in a consistent way. We noted there were separate meetings for nurses, carers, and kitchen and housekeeping staff. The attendance at these meetings was recorded. It was evident that staff took ownership of issues and participated fully. There were action plans drawn up after meetings, with clear timelines and responsible individuals named.

People and those important to them had opportunities to feedback their views about the home. Resident and relatives meetings took place to discuss various topics about the home. People and their relatives told us that they had been asked for their views about the home. One person told us, "They have meetings with residents, family and friends and we can go along if we want to and they give us forms for us to fill in, like questionnaires." Another person told us, "There are questionnaires I have done one." Minutes of meetings showed discussion of items important to people and their relatives, including the upcoming renovation and expansion of the home.

We looked at the results of returned satisfaction questionnaires, sent to both people and visiting professionals in January 2018. There was a high degree of satisfaction expressed by all, particularly in the areas of staff attitudes and the quality of care. For example, people were very satisfied in regard to the arrangements for their personal care, staffing and food. There was a survey returned by a GP. There was a high degree of satisfaction expressed in all areas identified.

Quality assurance systems were in place to monitor the quality and running of service being delivered. The provider told us in their PIR that regular audits were undertaken that included medicines, care plans, risk assessments, infection control and staffing at the home. We found this to be the case. The provider had employed a quality assurance manager who undertook monthly visits to the home to ascertain the quality of service provided to people. These audits were undertaken in line with the CQC five key questions of safe, effective, caring, responsive and well led. The registered manager had developed and completed an action plan for any issues identified during the monthly visit. For example, it was identified in the January 2018 audit that resident and relatives meetings should be undertaken on a regular basis. This had been actioned and future dates of these meetings had been sent to people and their relatives. Another identified issue was to provide a more varied menu, this was competed in February 2018 and people we spoke with were happy with the new menus.

The provider and staff worked with other related agencies that ensured people received joined up care, treatment and support. Records maintained at the home evidenced that staff work closely with the local safeguarding team, adult social care teams and all healthcare professionals. For example, GPs, occupational therapy, physiotherapy and dieticians.

The provider was aware of their responsibilities with regard to reporting significant events to the Care Quality Commission and other outside agencies. Notifications had been received in a timely manner which meant that the CQC could check that appropriate action had been taken.