Georgetown Care Limited

The Haven

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

At the inspection of the 11, 12 and 24 April 2017 we found consistent improvements were needed in Effective, Responsive and Well Led. At this inspection we found improvements had been imbedded into practice.

This inspection was unannounced and took place on 4 July 2018.

The Haven is a 'care home' for 12 older people. 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.

A registered manager was 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.

Risks were assessed and action plans were devised on minimising the risk. Individual risks to people included mobility needs and prevention of pressure ulceration and choking. However, risk assessment for the same identified risk were repeated and for some people the information was not consistent with each other.

Members of staff were knowledgeable on how risks were managed. Where people presented with behaviours that placed others at risk of harm the staff knew how to divert and distract people. The guidance was not detailed on how staff were to manage these levels of anxiety when people became frustrated. For example, how to distract and divert people. The registered manager made some risk assessments clearer during our inspections.

Mobility risk assessments were detailed on each movement and the equipment used. For one person the risk assessment should include the colour of the hoist. The registered manager added this information to the risk assessment.

Care plans were person centred and reflected people's physical, emotional and leisure needs. However, some care plans had been repeated and the information was not always detailed or consistent with each other.

Some people we spoke with told us they made their own decisions in relation to their health and welfare. Staff knew how to support people with the day to day decisions. People's mental capacity was assessed and best interest decision taken where they lacked capacity to make specific decisions. Care and treatment capacity assessment must include the specific decisions. For example, staying in bed for part of the week, thickeners, administration of medicines and photographs. We recommend the registered manager seek

from a reputable source the guidance on the assessments that must carried out for complex decisions made on behalf of people that lack capacity.

The arrangements for medicines were mainly safe. The introduction of Topical Medication Records (TMR) ensured staff consistently record the applications of topical creams and ointments. The directions of thickeners (used when people were at risk of choking) needed to be detailed in care plans. This information was updated by the registered manager during the inspection.

Audits were used to assess the quality of care. Where shortfalls were identified action plans were devised. However, the medicine audit had not identified that staff were not consistently signing records to show they had applied creams. The registered manager said these Medication Administration Records (MAR) had not being audited for June 2018 and this would be identified in the next audit. Person centred care was identified in the audits and staff were to attend further training. However, records were not always accurate. We made recommendations for the registered manager finds out more about developing care plans and risk assessments to ensure staff have detailed guidance on meeting people's needs.

The people we spoke with said they felt safe and the staff made them feel safe. The staff told us they had attended safeguarding training. They knew the types of abuse and what action they must take where there were concerns of abuse.

Incident and accidents reports were completed and analysed for patterns and trends.

Staff and professionals told us there had been improvements with staffing levels. Three staff were on duty during the day and two staff were awake in the premises at night.

Housekeeping staff were employed and schedules in place on maintaining the home clean and free from the spread of infection.

New staff had an induction to ensure they were confident to perform their role. Staff told us they had attended core training set by the provider as mandatory. One to one supervision ensured that staff were supported to maintain their skills and improving their performance.

People were supported with their ongoing healthcare needs. The staff organised routine visits with the GP and as needed for more urgent visits.

People knew who to approach with concerns. People told us the staff were caring and felt able to express their views about their care. They said the staff respected their rights. There were no complaints received since the last inspection. We observed staff engage and interact with people in a sensitive and kind manner. Relatives told us there had been improvements with staffing levels and with the environment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe.

Medicine records were not signed for topical creams and ointments and the directions for thickeners (used for people at risk of choking) were not specific.

Risks were identified but action plans were repeated and not always consistent with each other. Members of staff were knowledgeable on actions necessary to reduce risks.

There were sufficient staff to support people and we observed that staff were visible and available to people at different times of the day.

People said they felt safe and were able to describe what safe meant to them.

Staff attended safeguarding of vulnerable adults training which meant they knew how to recognise the types of abuse and how to report their concerns.

Is the service effective?

Good

The service was effective.

People's capacity to make decisions was assessed but mental capacity assessments must be specific on the decisions.

Staff enabled people to make choices.

The needs of people were assessed before their admission to the home.

The staff had the skills and knowledge needed to meet the changing needs of people.

People's dietary requirements were catered for.

Is the service caring?

Good

The service was caring

People were treated with kindness and with compassion.

We saw positive interactions between staff and people using the service.

Staff knew people's needs well and how to reassure them when they became distressed.

People's rights were respected and staff explained how these were observed.

Is the service responsive?

Good

The service was responsive

Care plans were person centred but the same area of need was repeated and the guidance was not consistent with each other.

People told us the staff knew their needs and how to deliver care in their preferred manner.

People had access to in-house activities. People were supported to maintain contact with relatives.

Is the service well-led?

Good

The service was well led.

Quality assurance systems and processes for assessing the delivery of care were in place. The action plan to drive improvements had detailed all the findings from inspection.

The views of people were gathered from feedback received and action taken to improve their experience in relation to meals.

Staff were aware of the values of the organisation. They said the team worked well together and the registered manager had introduced improvements.

The Haven

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 the 4 July 2018 and was unannounced. At the time of the inspection there were 10 people living at the service.

The inspection was carried out by one inspector 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.

Before the inspection, we reviewed all the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with two people and three relatives. We also spoke with housekeeping and catering staff as well as three care staff including a senior. The registered manager and deputy were part of the inspection.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included two care and support plans as well as three care records in relation to specific areas. We reviewed the staff matrix provided, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Requires Improvement

Is the service safe?

Our findings

Records were securely stored and available to relevant staff to support people to stay safe. However, we found the same area of need was repeated in different documents but the guidance was not consistent with each other. For example, the risk assessment for one person gave staff guidance to thicken liquids to a consistency of syrup (stage one). However, the instructions on other documentation was for custard thickness (stage two). This could have left people at risk of receiving inconsistent care and at risk of choking.

Arrangements were in place on how to manage risk. We saw monitoring charts for the intake of food and fluids and for repositioning were used to ensure the staff followed the actions on how to minimise the risks identified. However, where risk assessments were repeated the guidance was not consistent with each other. For another person documentation including capacity assessments showed that at times this person resisted personal care. The family had lasting power of attorney and had agreed for the personal care to be delivered. However, clear guidance was not provided to staff on how to deliver personal care that was the least restricted when the person resisted their assistance.

The staff we spoke with were knowledgeable about people's individual risk and the actions needed to minimise the risk. For example, there were people at risk of choking, pressure areas and with mobility needs. A member of staff explained there was regular repositioning and air flow mattress for people at risk of pressure ulcers. For people at risk of choking thickeners were used in fluids. Where staff supported people with transfers equipment such was hoists and slide sheets were used. For example, the hoist risk assessment for one person listed the number of staff needed. During the inspection the registered manager added the colour or size of sling needed for transfers.

We recommend that the registered manager seek guidance from a reputable source on developing comprehensive risk assessments and care plans.

The medicine administration file included individual profiles and medicine administration records (MAR). The person's photograph was attached to their individual profile to ensure staff could identify them. While staff mostly signed the MAR's when they administered medicines we found staff had not consistently signed the MAR when they applied topical medicines and used thickeners in liquids. The deputy manager told us topical medicine administration records (TMAR) were to be introduced.

Detailed protocols were in place for medicines prescribed to be taken "when required" (PRN). For example, one person's PRN protocol for anxiety included the signs of agitation and measures staff must take before administering PRN medicines.

A record of medicines no longer required by the person was maintained and signed by the representative of supplying pharmacist to indicate receipt of the medicines for disposal.

We noted during the inspection the medicine trolley was moved to another secure location because the

temperature was above the acceptable range of 25 degrees.

Systems in place ensured people receive their medicines as intended. The staff we spoke with told us they had attended training and were competent to administer medicines. People told us the staff administered their medicines. One person told us "the staff give them to me. They wait to see me take them. I have most of them in the mornings and on time". A relative said "They give the medicines. The medicine handling is very good. The staff are totally focused on doing medicines. We have asked for and got a meds review when the staff picked up on [family member's] drowsiness".

Arrangements were in place to manage risk safely. Risks were assessed and action plans were devised on how to minimise the risk. Monitoring charts for the intake of food and fluids and for repositioning were used to ensure the staff followed the actions on how to minimise the risks identified.

The staff we spoke with were knowledgeable about people's individual risk and the actions needed to minimise the risk. For example, there were people at risk of choking, pressure areas and with mobility needs. A member of staff explained there was regular repositioning and air flow mattress for people at risk of pressure ulcers. For people at risk of choking thickeners were used in fluids. Where staff supported people with transfers equipment such was hoists and slide sheets were used. For example, the hoist risk assessment for one person listed the number of staff needed. During the inspection the registered manager added the colour or size of sling needed for transfers. The swallowing risk assessment for the same person stated, "at risk of coughing when swallowing liquids. Thickeners prescribed."

Accidents and incidents were reported. The record of accidents for May 2018 showed there were five falls and eight falls in June 2018. Preventative actions recorded in the reports included the use of sensor mats, monitoring, positioning and wearing appropriate footwear.

Safeguarding of abuse procedures and practices were in place to protect people from potential abuse. People told us they felt safe living at the home and what made then feel safe. For example, fire safety precautions and the staff made them feel safe. A relative told us their family member was safe living at the home because preventative measures were introduced. For example, equipment used in their family member's bedroom to alert staff of falls.

The staff we spoke with told us they had attended safeguarding of adults training. The staff knew how to identify the signs of abuse and the actions they must take for suspected abuse

People told us there was enough staff to assist them. Comments made by people included "There's enough of them [staff]. I have a pull cord alarm in my room. In the lounge there is a buzzer, but I can assure you the lounge is never left without staff – there is always two".
Relatives and social and healthcare professionals told us staff were always available and present in the lounge when they visited. A relative told us "Yes, there is enough staff to meet their family members increasing need. I have complete trust that my [relative] is happy".

The staff we spoke with said staffing levels had improved. They said catering and housekeeping were recruited. The rota in place showed there were three staff on duty during the day and at night two staff were awake in the premises.

There were safe recruitment and selection processes in place to protect people. We reviewed the personnel file of the most recently employed staff and appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work

performance. New staff were subject to a Disclosure and Barring Service (DBS) check before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Systems were introduced to improve the protection and prevention from the spread of infection. The housekeeper told us they had attended training relevant to their role including infection control and Control of Substances Hazardous to Health (COSHH). The housekeeper told us they followed a cleaning schedule and we saw the schedule listed the areas to be cleaned daily. For example, bedrooms. The housekeeper then signed the schedule when the task was completed. We observed the premises were clean and there was an absence of unpleasant odours.

Good

Is the service effective?

Our findings

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

People's capacity to receive care and treatment at the home was assessed. Where people were assessed as lacking capacity best interest decisions were taken. We noted that best interest decisions did not include specific decisions such as the administration of medicines including thickeners in fluids, personal care and taking photographs. For example, the care plan for one person who lacked capacity showed they had bed rest three days per week. The best interest decision document for this person did not include having bed rest. The registered manager agreed to detail this information in the capacity assessments.

A care plan for another person stated, "son and daughter agreed for staff to deliver personal care in best interest even though resistive". The registered manager told us the relatives of this person had lasting power of attorney and were able to make these decisions. However, mental capacity assessments and best interest documentation for this particular decision was not in place.

We recommend the registered manager seek from a reputable source the guidance on the assessments that must carried out for complex decisions made on behalf of people that lack capacity.

People told us they made their own decisions. One person told us "Decision making is not a problem. I make my own decisions". A relative told us their family member was "only able to make short term decisions e.g. cup of tea, I make the day to day financial decisions". The staff told us the day to day decisions people made. The staff we spoke with told us how they enabled people to make day to day decisions. A member of staff gave us examples on how one person made decision. They said one person used nonverbal language to make decisions such as smiling and staff enabled this person to make choice by giving them visual choices.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. DoLS application for continuous supervision and for care and treatment were made and were in progress. The registered manager reviewed outstanding DoLS to ensure applications contained all relevant information.

When people were referred for care and treatment at the home their needs were assessed by the staff before their admission. The comments from people included "I came in one morning to meet the staff. I stayed for two hours to see my room and see if I liked it". "No, I didn't meet the staff before I came here but my family did". They wrote it all down. I told them about my (health need). They covered everything that was

important to me – asked if I was afraid of the dark. I knew they could help me".

Admission assessment documents included people's personal details and medical history with an assessment of their physical, mental and social care needs. For example, communication, eating and drinking and mobility. Social workers comprehensive care plans were also provided before the admission of some people. Within the comprehensive care plans the needs identified were listed with the assistance needed from staff to meet the needs.

New staff received an induction when they started working at the home. Staff told us their induction included core training set by the provider. For example, safeguarding, fire safety, moving and handling and first aid. Two members of staff told us shadowing more experienced staff was part of their induction. They said this was for them to get used to people's routines.

The staff were supported to develop their skills and to meet the accountabilities of their roles. The comments from people included "They know how to look after me. They're very observant. They don't miss out on anything. They ask about any sore places etc. when you have a bath". "I like the staff. They all work together. I have nothing to worry about in the world. Nothing is too much trouble" and "I like the staff. They are wonderful". A relative told us "They do have the right skills and knowledge. It is really important. Since the last CQC report they have taken training very seriously. They have a very good induction. If staff are not up to it, they are out".

Staff told us they attended core training set as mandatory by the provider which included Basic Life Support, First Aid, Food Hygiene, Infection Control, Safe handling of meds, Moving and Handling, Safeguarding and MCA, Dementia and End of Life. They said there was a combination of online and face to face training. We saw that training courses were booked in advance and included Creative activities, Duty of Candour, Record Keeping, Epilepsy, Dementia workshop and Safeguarding.

One to one supervision meetings to monitor staff's performance, discuss issues of concern and training needs were with the registered manager.

People were supported to maintain a balance diet. Comments from people included "The food is OK. Choice – not really. Sometimes they bring me what I didn't order." "Yes, I get enough to eat." "The food quality is good. I get enough to drink". "I can't complain about the food at all. Bread I must not have. There is a choice of food. They tell you the day before e.g. roast or salad. You know you're going to eat something you'll like and enjoy".

Staff told us that people had a choice of two main courses at lunch time. Choices were made the evening before using pictorial menus. Checks were made the following morning to ensure that people still wanted the meal they had chosen the evening before.

On the day of the inspection the weather was very warm and we noted refreshments were available and regularly offered to people. People were served their meal in the lounge/diner or in their rooms. Staff offered help with food which was encouraging and at a pace led by the individual. For example, reminding people they had a spoon to enable independence and offering a smaller portion.

The chef told us there was a three-week rolling menu which they prepared with the registered manager. The menus in place were for the main cooked lunchtime meal and a lighter tea time meal. The chef told us people made the decision about what to eat for breakfast. People's food preference and dietary requirements was recorded in the "Grab" sheets kept in the kitchen. We saw some people were served with

enriched diets, gluten free and soft meals.

People were supported with their ongoing health and wellbeing needs. Comments from people included "The doctor would come on the day you felt poorly. They're good at picking up quickly if you're not well. The doctor is here in 30 minutes". "Yes, you can see a doctor if unwell. They pick up quickly if you're not feeling so good. The doctor is here quickly". A relative told us "Yes, ongoing health care is addressed. They noted weight loss and informed the GP. End of Life care has also been discussed. Here they'll [staff] care for their [family member].

A member of staff told us that on Mondays the senior on duty will contact the GP surgery and arrange routine visits. They said urgent visits were arranged as needed. We saw where healthcare professionals had confirmed in writing outcomes of their visits. For example, mental health team and optician visits.

The décor and adaptation of the property ensured people's access needs were met. A lift to all floor ensured people unable to use stairs had access to the upper floors. People had access to a downstairs lounge/dining room and conservatory. On the day of the inspection the conservatory was not used because of the warm weather. The garden from the conservatory was recently paved for people to access more easily. We looked around the premises and found people's bedrooms were personalised with their belongings.

Good

Is the service caring?

Our findings

People told us the staff treated them with kindness and compassion. Their comments included "100% kind and caring. If you need something they are here. I like to make my own bed. They make sure it's what I want to do. This is my home and I want it like I want it". "Yes, they are kind and caring. They come in, give me a drink and refill it". A relative said "Very caring". With no exceptions staff were observed being extremely kind, respectful and knowledgeable of each person's needs.

Staff told us that building relationships with people was important. A member of staff said they listen to people and "I have a positive attitude, I always smile and read care plans". Another member of staff said, "we give people 'a voice'. We explain to people what is happening before undertaking tasks. We treat people as individuals. We spend time with people".

The registered manager said that suitable staff were employed to provide care and treatment in a kind and compassionate manner. They said recruitment process and the "in-depth" induction ensured people received consistent care from staff. There was close observation and one to one supervision of staff and reflective practice on performance was encouraged. Also feedback from people was welcome.

We observed staff manage situations in a compassionate manner when people became unsettled. We saw staff consistently respond to people that used repetitive behaviour. For example, a member of staff said to one person that was unsettled "I know your [relative] loves you dearly and he will visit you". On another occasion a member of staff said to the same person "your [relative] visits regularly and I am sure they will visit soon". The person accepted the staff's comments and settled back to watching television. A relative told us "staff are lovely my [family member] is very affectionate towards staff. The emotional feeling, she has is good to watch. They [staff] laugh and jokes and she laughs and jokes back."

There was good interaction between people and staff. We observed the lunchtime meal and staff served meals to each person in a manner which was both organised and relaxed. Those requiring assistance were helped with protective clothing which afforded respect, dignity and knowledge of individual needs. On the front of individual care records "the support I need", "the things that are important" and the "things I like" were listed. For example, for one person two staff were needed for support, a close relative was important and hobbies were the things this person liked.

Where the views of people were sought action was taken. The action from the surveys were detailed in the "you said we did" notice on display which updated people on the garden upgrade. A relative told us "There are relatives meetings twice a year. They try to make it a social event for relatives and residents. They try to make it a family barbecue. I would not hesitate to phone the home owner or the manager or deputy. I would be listened to".

People were treated with fairness in decisions that were made in their best interests and their decisions were also respected. The dignity board on display in the home gave staff information on the principles and guidance on how to deliver care in a dignified manner. A member of staff told us how they respected people

rights which included allowing people to be independent and respecting their choices. Another member of staff said, "people that lack capacity still make choices although some were made on their best interest."

People told us their rights to privacy was respected. Their comments included "Yes, they respect my privacy. They come and close the door". "Yes, privacy is respected. I've never known no one coming in the door without knocking".

The Butterfly policy on display in the home explained to people that they can request the gender of the staff that provide their personal care. A pink butterfly on bedroom doors will tell male staff the person's preference is for female staff only. People told us "There are two men staff about. They don't do any personal care". "They're all women – except one young man who is here now and again. Not a problem".

Good

Is the service responsive?

Our findings

At the inspection dated 11,12 and 24 April 2017 we rated Responsive as requires improvement because further improvements were needed from the previous inspection. At this inspection we found improvements were consistent and were embedded into practice.

While people told us, their care was person centred they were not sure if they were involved in the planning of their care. People told us "Yes, I think all the staff know everybody individually. They know us all," "Oh yes. They definitely treat me as an individual" and "Yes. They treat me as an individual". Relatives told us they were invited to care plan review meetings.

People's care plans were person centred and reflected their physical, social and emotional care needs. Some action plans did not give staff clear guidance on how to meet people's needs. For example, the Keeping safe care plan for one person stated the equipment such air flow mattress and cushions were used to relieve pressure areas. The nutritional risk assessment identified that this person's skin integrity was poor. The pressure care risk assessment placed the person at risk of developing pressure ulcers. However, staff were not referred to the integrity care plan where guidance was given on how to identify signs of skin breakdown. The care plan was reviewed on the 26 April 2017 which stated the person was to have bed rest three days per week. Missing from the care plan was the frequency for repositioning when this person was cared for in bed.

The same area of need was often repeated in other care plans but the information was not consistent with each other. For example, for one person the how to support me at the front of their care records stated assistance was needed with personal care as "often refused". "Two staff were needed and one [staff] was to distract". The review notes dated 6 April 2017 in the communication care plan stated that relatives had made "a best interest decision for staff to deliver personal care even though the person can at times resist assistance". The review notes dated 12 June 2018 stated, "resists personal care, distraction and support from two carers appear to work well". This meant clear guidance was not provided in a personal care plan which detailed how to deliver personal care. Despite these shortfalls the staff had a good understanding of people's needs. The staff said having a small team ensured they were knowledge about people's needs.

People's background histories on their education, work life, family network, hobbies and interest was repeated at the front of the care records, in the "this is me" document and in My support plan. Staff reported in the daily notes their observations of people, direct care provided and meals served.

We recommend that the registered manager seek guidance from a reputable source on developing comprehensive care plans.

Communication care plans demonstrated that steps were taken to support people in line with The Accessible Information Standard (AIS, introduced by the Government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand). For one person the communication care plan detailed to staff how to approach the person when they were reluctant to engage

with them. For example, staff were to address the person by name and at eye level. Also stated was that the person did not respond to visual prompt cards. The staff told us the person responded to visual choices.

The epilepsy profile for one person told the staff the types of seizures the person experienced and how staff were to support the person during a seizure. The actions for prolonged and persistent seizures were detailed. For example, contact emergency service for prolonged seizures. Staff documented when this person experienced seizures and the actions they took.

People were making advanced decisions about the priorities of care at the end of their life. Treatment Escalation plans were in place where there were do not attempt resuscitation orders. The person's capacity to make decisions about their resuscitations, the rationale for the decisions and the people consulted were included in the orders. A relative told us there were discussions about their family members end of life plan. They said "Here they'll [staff] care for [family member]. The advance care plan for one person included their decision to remain at the home for end of life care and their funeral arrangements.

Staff told us the care plans had been developed by the registered manager and deputy. A member of staff said the senior reviewed care plans and the staff were to attend training for them to also review care plans. This member of staff also said the care plans were "more robust and informative". They said some areas of the care plan could be "tweaked. We try and keep them updated as needs change."

People were supported to pursue their interest. Staff told us they provided the programme of activities. They said when there were changes to the programme it was "to meet individual needs". The activities that took place during the inspection were manicures and bingo and were the same as in the activities board for that day. A member of staff said they helped with in-house activities such as bingo. Another member of staff said the in-house activities were improving and were developed around people's interests and hobbies which helped them build relationships with them. This member of staff said a "reminiscence map" was also used and people enjoyed participating.

The activities care plan for one person included watching DVD, Bingo, and watching the world cup. We were shown the garden area that was being developed into a "more sensory garden" which staff told us people had helped with.

The complaints procedure was on display in the home. The procedure gave people and their relatives information on who to approach with concerns. One person told us "I have no complaints." This person also explained that when one person with "Alzheimer's came in. I pulled the alarm and they came and got her". A relative told us "I am confident in raising concerns. I have never been told the procedure for escalating concerns".

Good

Is the service well-led?

Our findings

The values of the home helped staff develop a positive culture. The registered manager said the values included: compassion, respect, dignity and empowerment. A relative praised the staff for the way they met the duty of candour (healthcare professional must be open and honest when something that goes wrong with their treatment or care causes harm or distress). They said when an incident occurred with a member of staff they were informed and the registered manager took immediate action. Staff told us how the values of the home were put into their day to day practice. A member of staff said, "giving people choice and improving people's independence. Person centred care." Another member of staff said "we try and provide an excellent level of care. We try and make people and their relative feel included".

A registered manager was in post. Staff told us the team worked well together. Comments from staff included "it's like a big family. We all work well together, we get on well together. We have enough time to undertake tasks." "The shifts just flow. The [registered] manager is approachable." The [registered] manager and deputy are always there, very receptive to ideas and suggestions. They are fair but tough when needed". A relative told us that staff morale had improved and long-term plans were "being worked on" and the environment was improving for example the kitchen was refurbished. This relative also said the directors were visiting and relatives could approach them. Another relative told us "[I] would want to live at the service if [I] was in the same circumstance [as my family member]".

Systems were in place to assess and monitor the quality of care people receive. The registered manager undertook quarterly audits and action plans were devised where shortfalls were identified. Areas for improvement included activities, person centred workshops for staff, developing end of life plans and the environment.

People's views about the service were sought. The results from a recent survey showed that people had generally rated the quality of their care as good. However, 60 percent were satisfied with leisure activities and relatives had requested a "gallery of staff" for them to identify staff and their various roles. A relative told us that at a recent house meeting they were informed about the inspection reports. They said "long term plans were being worked on. The environment had improved."

Audits were used to assess the outcomes of care delivered by the staff. The medicine audit dated 21/05/2018 showed all areas checked were met. We identified at the inspection that medication administration records (MAR) were not consistently signed to show medicines administered. The registered manager said the audit for June 2018 had not taken place and these areas were to be picked up at the June audit. A sample of care plan were audit 31/05/2018. The audits of three care records included capacity assessments, monitoring charts and multi-agency records. The registered manager said a sample of three per month. Infection control audit dated May 2018 indicated all set standards were met.

the Local Authority that fund some placements at the home carried out a visit to ensure the home met their set standards. The report dated 19/04/2018 made recommendations to provide workshops to staff on communications and person-centred dementia care. We saw coursed were booked for staff and included in

the quarterly audit action plan.

The staff received feedback in a constructive manner from the managers. The minutes of the team meeting dated 4 May 2018 the staff discussed medicines procedures, scenarios of possible safeguarding were discussed and the employee of the month was selected. The minutes for the team meeting dated 25 May 2018 showed the focus of the meeting was to develop better team working between staff. On the 29 May 2018 the staff discussed safeguarding procedures.

The registered manager told us how continuous learning was used to drive improvements. The registered manager told us there had been learning from previous inspections. Where shortfalls were identified at the inspection they were "overcome". Also, that "auditing systems had helped to identify trends to develop action place with control measures. This registered manager said that lessons to be transparent were learnt from attending safeguarding meetings. They said this had been a valuable resource of information and [thought them] not to be "scared of holding your hands up and admitting to mistakes.

The registered manager said, "building on the good reputation and marketing to increase the occupancy of the home" promoted sustainability of the service. They said, "the service was running efficiently and that makes it worthwhile. [I am] honest and straightforward with the expectations. [I] give hands on support and ensure everybody [staff] understand what I want to achieve by when and why."

Links with the community were being strengthened. The registered manager told us "stronger relationships were being built. For example, annual carol service, religious services from local volunteers and visits from school children". Local businesses were contacted for support with the annual local fete where staff raised funds for Alzheimer's Society.