HC-One Limited

Defoe Court

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

This inspection took place on 20 and 24 April 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

Defoe Court provides general nursing, residential and respite care for older people and people with a dementia type illness. On the day of our inspection there were 41 people using the service.

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

Defoe Court was last inspected by CQC on 13 May 2014 and was none compliant in one area; respecting and involving people who use services.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Summary of findings

Thorough investigations had been carried out in response to safeguarding incidents or allegations and comprehensive medicines audits were carried out regularly by the nursing staff.

Staff training was up to date and staff received regular supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

The home was clean, spacious and suitable for the people who used the service.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We discussed DoLS with the registered manager and looked at records. We found the provider was following the requirements in the DoLS.

People who used the service, and family members, were complimentary about the standard of care at Defoe Court.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

We saw that the home had a full programme of activities in place for people who used the service.

Care records showed that people's needs were assessed before they moved into Defoe Court and care plans were written in a person centred way.

The provider had a complaints policy and procedure in place and complaints were fully investigated.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

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.

There were sufficient numbers of staff on duty in order to meet the needs of people using the service and the provider had an effective recruitment and selection procedure in place.

Thorough investigations had been carried out in response to safeguarding incidents or allegations.

Comprehensive medicines audits were carried out regularly by the nursing staff.

Good

Is the service effective?
The service was effective.

Staff training was up to date and staff received regular supervisions and appraisals.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Good

Is the service caring?
The service was caring.

Staff treated people with dignity and respect.

People were encouraged to be independent and care for themselves where possible.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Good

Is the service responsive?
The service was responsive.

Risk assessments were in place where required.

The home had a full programme of activities in place for people who used the service.

The provider had a complaints policy and complaints were fully investigated. People who used the service knew how to make a complaint.

Good

Is the service well-led?
The service was well led.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the registered manager was approachable and they felt supported in their role.

Good

Defoe Court

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 20 and 24 April 2015 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector, a specialist advisor in nursing and an expert by experience took part in this inspection. 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 we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners, safeguarding staff and the infection prevention and control team. No concerns were raised by any of these professionals.

For this inspection, the provider was not asked to complete 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. We gave the provider the opportunity to inform us of planned improvements during the inspection and in the weekly action plans.

During our inspection we spoke with ten people who used the service and four family members. We also spoke with the registered manager, deputy manager, nurse, activities coordinator, four care workers and one visiting professional.

We looked at the personal care or treatment records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe at Defoe Court. They told us, "Yes" and "Very safe".

We looked at the recruitment records for four members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We looked at the staff rotas and the registered manager explained that they started preparing the rotas eight weeks in advance. Staff were given two weeks to complete their requests before the registered manager produced the final rota. The registered manager told us gaps were usually covered by their own staff, some of which had a "job two", which meant staff could perform a second role. However, the home did have access to bank staff if required.

People we spoke with did raise some concerns about staffing levels. They told us, "Sometimes at night there is only one carer available, then I have to wait until the nurse has finished her late drug round and come to help. It can be past midnight before I am in bed", "They get hold ups then I have to wait to get up" and "There have been some staff shortages recently". We discussed these comments with the registered manager who told us, and staff rotas confirmed, there had not been any staff shortages recently. The registered manager told us, "Some people want attention straight away." During our visit we observed sufficient numbers of staff on duty and call bells were answered promptly.

The home is a two storey building set in its own grounds. We saw that entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, spacious and suitable for the people who used the service. The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. We saw window restrictors, which looked to be in good condition, were fitted in the rooms we looked in.

We saw maintenance records for the home, which included lift servicing, fire alarm and safety equipment, portable appliance testing (PAT), legionella, gas safety, lifting operations lifting equipment regulations (LOLER), boiler servicing, emergency lighting, nurse call and electrical installation. We also saw from the maintenance file that routine room checks were carried out weekly, which included checks of window restrictors, lighting and hot water. We saw all the hot water temperatures were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014.

We saw a maintenance action plan was in place for any identified issues and included the date of the action, summary of the action required, date action completed and initials of the person carrying out the action. For example, we saw that a person's bedroom light needed a new bulb. The action was recorded as being completed the same day. We checked and confirmed this action had been carried out.

The service had a fire folder in the main foyer, which included Personal Emergency Evacuation Plans (PEEPs). These were in place for all the people who used the service.

This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We saw a copy of the provider's safeguarding policy dated November 2014. We looked at the safeguarding information and alerts file and saw a copy of the local authority safeguarding adults risk threshold tool, which was used to gauge vulnerability, impact of abuse and the risk of a repeat. We saw the safeguarding log, which included the date of each incident, a description of the incident, who it was reported by, what the outcome was and any additional comments. Each incident had a full safeguarding report completed and recorded whether it had been reported to the local authority safeguarding team and what actions had been taken as a result of the incident. For example, a controlled drug medication error was reported to the local authority as an alert. All staff had

Good

Is the service safe?

been reminded of the importance of following company policy and procedures for the administration of controlled drugs and we saw the local authority were happy with the action taken by the home.

We saw the accident and incident records file, which included copies of reporting forms. These included details of the person involved in the incident, a description of any injuries and how the incident occurred. We discussed incident recording with the registered manager who told us all incidents were recorded on the provider's electronic incident recording system and formed part of the home's key performance indicators. The registered manager told us that analysis was carried out to see if there were any trends and this was used to identify whether any equipment was needed, such as falls mats or sensors.

We looked at the management of medicines and found that the service had up to date evidence based policies and procedures in place, which were regularly reviewed, to support staff and to ensure that medicines were managed in accordance with current regulations and guidance.

We were told that one person who used the service took responsibility for administering some of their own medicines. We saw that assessments had been completed with regard to their 'medication capacity' and whether the person was able to administer their medicines independently or needed support and this was monitored by staff. This meant there were systems in place to support people to take their own medicines, promoting their independence.

We saw there was written guidance, accompanying the medicines administration records (MAR), for the use of when required (PRN) medicines, and when these should be administered to people who needed them, such as for pain relief. We saw that PRN medicines were offered when people were experiencing symptoms for which the medicines was prescribed, and were not restricted to the times of the medicines round.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs (CDs), which are medicines which may be at risk of misuse. The controlled drugs book was in order and medicines were clearly recorded.

We observed a medicines round on the ground floor on the second day of the inspection. Medicines were given from the container they were supplied in. We saw the staff member explain to people what medicine they were taking and why. They also supported people to take their medicines and provided them with drinks, as appropriate, to ensure they were comfortable in taking their medication. We saw the staff member remain with each person to ensure they had swallowed their medicines and signed the medication administration records (MAR) after administration. Medicines were not left unattended and the trolley was locked between each administration.

MAR charts showed that on the day of the inspection staff had recorded when people received their medicines and that entries had been initialled by staff to show that they had been administered. We checked the medicines for four people and found the number of medicines tallied with the number recorded on the MARs.

Medicines requiring cool storage were kept in a fridge which was locked; with dates of opening seen on eye drops, which were within a shelf life of four weeks. We saw that temperatures relating to refrigeration had been recorded daily and were between two and eight degrees centigrade. We saw that temperatures for the treatment room were recorded daily and they were less than 25 degrees centigrade. This meant that there was the correct storage of medicines which ensured the overall safety and effectiveness of medicines.

The nurses were responsible for conducting monthly medication audits (which were reviewed by the registered manager), including the MAR charts, to check that medicines were being administered safely and appropriately. The registered manager showed us the medicines audit for March 2015, which identified two non-compliant areas and had the following action points recorded, "Gaps on MAR chart and safeguarding alert made re. medication" and an entry related to homely remedies "Needs to be reviewed". The home manager showed us the recent medicines audit result for April 2015 which demonstrated that the previous action points had been addressed and 100% compliance had been achieved.

Good

Is the service effective?

Our findings

People who lived at Defoe Court received effective care and support from well trained and well supported staff. Family members told us, “The staff are absolutely brilliant”, “Nothing is too much trouble” and “The staff make the home”.

We saw the provider’s electronic training matrix, which included the training records for all members of staff and was colour coded to show whether training was in date, due or overdue. We saw that where there were any gaps, training was planned. For example, manual handling training was booked for 23 April 2015 for those members of staff who’s training was due.

Training was split into two categories. ‘Compliance’ training was mandatory for all members of staff and included emergency procedures, fire drills, food safety, health and safey, infection control, manual handling, safeguarding and equality and diversity. ‘Required’ training was role specific training and included medicines competency training, promoting healthy skin, catheter care and open hearts and minds, which was specific training on dementia and understanding and resolving behaviour that challenges. We also saw staff had completed an induction to the role.

Staff told us their training was regular, thorough and continuous. One care worker told us, “I have received more training here in five months than I received in five years in my previous job.” A new member of staff told us, “I received a thorough induction and now am on more advanced training. All the other staff have really supported me and we work as a good team.” Staff also told us, “Not only do we do basic training but we keep learning new things that can help us in looking after residents. We are doing osteoporosis training tomorrow and we recently completed catheter training.”

We saw that staff received regular supervisions and appraisals. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Supervision records we saw included discussions regarding training, how the member of staff was performing in the role and any training needs. All the records were signed and dated by the member of staff and the supervisor.

We saw from the appraisals planner that all the appraisals, except one, scheduled for January and March 2015 had been completed and the remainder were scheduled during the remainder of the year. We checked staff files and saw records of these appraisals, which included a review of job knowledge, demonstration of values, initiative and enthusiasm, team work, time keeing and attendance, attitude and appearance and an action plan. All the records were signed and dated by the member of staff and the supervisor.

This meant that staff were properly trained and supported to provide care to people who used the service.

There was a separate dining room on each floor and residents could choose whether to use it or to eat in their rooms. The menu, which had a four week rotation plus seasonal changes, was displayed outside the dining room and people chose their meal at the point of service. We saw that alternative options and snacks were also available. However, we saw some of the people with a dementia type illness did not appear to properly understand the choices being offered verbally rather than being shown each dish and the carers had to make the decision. We also observed that although there were several members of staff around the service area only one was available to help those who needed encouragement or help with feeding. We discussed this with the registered manager who agreed to look into it.

The food provided was well presented and plentiful. We discussed diet with a care worker, who told us they were getting an increase in people who needed soft diets or pureed food.

Malnutrition Universal Screening Tool (MUST) risk assessments were used to identify specific risks associated with people’s nutrition. These assessments were reviewed on a monthly basis. Where people were identified as being at risk of malnutrition, referrals had been made to the dietitian for specialist advice.

For people who were identified at risk of poor nutrition staff kept daily records of how much people ate and drank, as described in their care plan. People were weighed and their weight was monitored in accordance with the MUST score to determine if they were at risk of malnutrition. This information was used to update risk assessments and/or refer to the GP/dietician if weight loss was identified. This meant staff could monitor people and would know if their health deteriorated.

Good

Is the service effective?

Records we looked at included notification to the kitchen regarding food likes, dislikes and dietary needs. Records also included details of specific diets and recorded that "Catering staff must be provided with the diet notification sheet".

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We discussed DoLS with the registered manager, who was aware of their responsibilities with regard to DoLS.

We saw a copy of the provider's DoLS procedure and a DoLS guide had been produced for staff in January 2015. We saw that 24 DoLS applications had been submitted to the local authority in February and March 2015 and that mental capacity assessments and best interests decisions had taken place. This meant the provider was following the requirements in the DoLS. We also saw staff had received training in the Mental Capacity Act and DoLS.

Records we looked at provided evidence that, where necessary, assessment had been undertaken of people's capacity to make particular decisions. We saw this assessment had been completed in accordance with the principles of the Mental Capacity Act (MCA). An example of this related to consent to bed rails. We also saw a record of a best interest decisions meeting, which involved the family and the record was signed by the person's next of kin and the lead healthcare professional. This meant that the person's rights had been protected as unnecessary restrictions had not been placed on them.

We saw 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were in people's care records. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). These were up to date and showed the person who used the service, family members and relevant healthcare professionals had been involved in the decision making process.

We saw evidence of consent in the care records. For example, "I am living within this care home and have been involved in the formation and agreement of my plan of care" and "I have reviewed my plan of care". Both of these statements were signed and dated by the person using the service. We saw evidence regarding person/family/ advocate involvement in care planning, together with their signatures confirming involvement. We also saw consent was obtained to have photographs taken. This meant that people were consulted about their care, thus ensuring the quality and continuity of care was maintained.

In the care records, we saw records of professional visits, such as GPs, nurses and the adult sensory support team. We also saw relatives communication records, where relatives had been informed of any concerns or appointments and referrals to hospitals and GPs. We saw that healthcare such as opticians, chiropodists and dentists were arranged on site, and people requiring hospital visits were always accompanied by a member of staff, some of whom may have been called in specifically, if a family member was not available.

We looked at the design of the home for people with dementia. We saw that handrails were painted a different colour to the walls and saw that people's bedroom doors were clearly labelled with the person's name, room number and, in some cases, a photograph. Dementia friendly signage was in place to help people find the dining rooms, lounges and toilets but there were few pictures or displays to provoke interest, particularly for people with a dementia type illness.

Good

Is the service caring?

Our findings

People who used the service were complimentary about the standard of care at Defoe Court. They told us, "I'm quite happy here. If anyone asked me to recommend a care home I would recommend this one" and "Service here is good. If I ask for something I usually get it".

The care records we looked at contained evidence that people had been involved and their wishes were taken into consideration. For example, we saw the care records included a section where the person could say what was important to them and what they enjoyed doing. For example, "[Name] always likes to look smart and likes to wear trousers and shirts daily" and "[Name] enjoys gardening".

Care reviews showed that people were involved in planning their care and their wishes were taken into consideration. The reviews provided information and guidance for staff so they understood the person's wishes. For example, "[Name] likes staff to understand what she is trying to communicate and can become frustrated when staff do not understand", "[Name] does not like coming out of her room but does enjoy staff coming into her room and chatting with her" and "[Name] needs encouragement with all her meals and fluid intake".

We found the care planning process centred on individuals and their views and preferences. Care plans contained information about people's life histories. This information supported staff's understanding of people's histories and lifestyles and enabled them to better respond to their needs. We saw care plans were in place for routine on waking, personal hygiene, elimination and toilet, eating and drinking, daily activities, likes, dislikes and allergies, mobilisation, routine on retiring, sleeping and night time routine, general physical health, general psychological health, antibiotics, medicines, ensuring safety, oral care, respecting, end of life care and promoting independence.

Although none of the people we spoke with could recall having a care plan, the plans we saw described people's individual wishes and needs. For example, the respecting care plan for one person described, "I would like all staff to ensure that they keep my bedroom door closed and my curtains shut if I need them to assist with my care" and "Please respect all my preferences and ensure that I stay the individual I am".

We asked people and family members whether staff respected the dignity and privacy of people who used the service. They told us, "Oh yes" and "Staff pick me up if I don't close the curtains".

The end of life care plans provided details of how the person wanted to be supported and who they wanted involved, for example, whether a DNACPR was in place and who their next of kin was.

The promoting independence care plans informed the staff what the person could do independently and what tasks the person needed support with. For example, "I am able to do all daily tasks myself", "I have difficulty making my bed and opening my blinds each morning", "If I need assistance I will ring my buzzer" and "I do not like staff to take over or assist with any parts of my care unless I ask".

We saw information about people's social and spiritual preferences. In addition, we saw a copy of the 'Remembering together. Your life history' document, which was used to plan the person's care and give the care team an understanding of the person and how their life influences how they are today. A staff member told us that the social care assessments were under development and this was also noted on a recent care file audit. This meant that information was available to give staff insight into the interests of a person and to enable them to better respond to the person's needs.

Our observation during the inspection was that staff were respectful when talking with people calling them by their preferred names. We observed staff knocking on doors and waiting before entering.

We saw people who used the service had positive and caring relationships with staff. Staff were seen chatting on a one to one basis with people, offering reassurance if people were upset or distressed and responding to people with understanding and compassion. We observed one person ask a member of staff for a cup of tea. The staff member obliged and brought the tea to the person's room. We also saw staff accompanying people as they mobilised around the building, offering encouragement and providing assistance only when needed to promote people's independence. People were asked what they wanted to do and staff listened. People appeared comfortable in the

Good

Is the service caring?

presence of staff. We heard one person say, "I love [Name] to bits", referring to a member of staff. People looked well presented and well cared for. They had clean clothes and their hair was styled and brushed.

We asked a visiting healthcare professional about their views of the staff and the home. They told us, "The people are cared for, the staff are really good, they use the hoist correctly, they use slide sheets and alternating mattresses, they understand they need to check mattresses, they do care", "They are very caring and encourage people to have a voice", "They read up to further their knowledge", "I'm really impressed by them" and "They promote the dignity and privacy for patients, they use a cover sheet and close the door".

We saw people who used the service could choose their own routines. One person told us, "I like to be on my own. My niece brings me videos to watch or I watch football in my room". We saw friends and family had open access to the home and some took their relatives out.

The home manager told us that in response to the Care Quality Commission's comments at the previous inspection they were trialling the '24 hour intentional rounding checklist'. Intentional rounding involves care staff carrying out regular checks with individual people at set intervals, which can improve people's experience of care and helps ensure that care is safe and reliable.

This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated.

We looked at the care files and found that the service had an up to date 'care planning procedure' in place, which was regularly reviewed, to support staff and to ensure that care was delivered to people, taking into account their ever changing risk assessed personal needs.

We saw one page profiles contained with the care files detailing 'what people like about me and admire about me', 'important things about my life', 'during the day I enjoy', together with 'my personal care needs'.

Following an initial assessment, care plans were developed detailing the care needs/support, actions and responsibilities, to ensure personalised care was provided to all people. The care plans guided the work of team members and were used as a basis for quality, continuity of care and risk management.

The care plans we looked at included a dependency needs score, which was reviewed on a monthly basis.

We saw a 'care review matrix' which showed that reviews of care were carried out for all the people who used the service every three to six months. The reviews included a summary of the last review, how the person had been since the last review and reviews of health, mental health, incidents and accidents, medicine changes, nutritional information, resuscitation wishes, activities, relationships, risk assessments, views of the person, family, social worker and staff, skin integrity, compliments and concerns and action points.

Daily accountability notes were comprehensive and information was recorded regarding basic care delivered and details of interactions with the person, information about behaviour, mood or presentation and involvement/ recommendations of healthcare professionals. In addition, the accountability notes were dated, timed and signed by the member of staff, together with a note made of the associated care plan number. This meant that people were appropriately cared for and supported as records were complete.

We found that risk assessments were in place, as identified through the assessment and care planning process, and they were regularly reviewed and evaluated, which meant that risks were identified and minimised to keep people safe. These covered the key risks specific to the person such as moving and handling, falls, nutrition, choking, continence and Waterlow pressure ulcer score. In addition, risk assessments were in place for use of the nurse call system, wheelchairs, smoking, bedroom fire and bed rails.

We saw a notice advertising what activities were taking place in the home in April. These included an easter bonnet competition, mad hatters tea party, grand national sweepstake, gardening competition, confectioner visit, chair exercise class and St George's day fish and chips. The birthdays of people who used the service were also posted on the notice boards, along with hairdresser prices, a copy of the provider's newsletter and parish magazine. We observed the activities coordinator asking and encouraging people to join in a chair exercise session with an external activities specialist.

We saw the home had a minibus, which was used to take people on excursions such as the railway museum and local parks. We saw one person was taken out by a friend to play bowls and some people went to bingo twice per week. One person told us, "I would like to go out more but on a one to one basis, not in a minibus full of people." Other people we spoke with told us, "My wheelchair is awkward so I don't get out much" and "My new wheelchair is too heavy for my wife to push so I cannot go out". Following the inspection we discussed these concerns regarding wheelchairs with the registered manager who told us funding had been applied for and agreed to provide new patio doors and improved patio areas to allow people with wheelchairs easier access to outside spaces.

The home employed an activities coordinator, who provided group and one to one activities in the home. We also saw people had records in their care files that described what activities had been offered to the person and what had been carried out.

The activities coordinator told us that people were taken out to the local park and explained about the home's relationship with the local schools, which included choir and musical events and arts and crafts. The activities coordinator also told us that one of the people who used the service was the bingo caller and that funding had been obtained from the provider to develop the garden areas at the home.

Good

Is the service responsive?

The home had a regular 'social life' meeting, which was attended by the registered manager, activities coordinator, chef and people who used the service. We saw the minutes for the meeting on 19 March 2015, which was attended by seven people who used the service, and saw that discussion subjects included money raised for charity, exercise classes, meals, entertainment, gardening and suggestions from people and staff for excursions. This meant that people who used the service were consulted about activities and entertainment that took place in the home.

We saw the provider's electronic compliments and complaints system and details of individual complaints. The provider's complaints policy and procedure was made available to people and visitors and explained that each complaint would be responded to within 24-48 hours and an investigation and response would be carried out within 14 days. Each record included details of the complainant, any other people or staff involved and details of the complaint. We saw copies of original letters and letters sent to the complainant acknowledging receipt of the complaint. We also saw copies of the outcome of the complaint, including the final letter sent to the complainant. The service had only received one complaint within the last 12 months.

People, and their family members, we spoke with were aware of the complaints policy but did not have any complaints about the service.

We asked a visiting healthcare professional whether they had any concerns or complaints. They told us, "No concerns, I've been in about eight times over three years and have no concerns. They really go out of their way and look outside of the box. I've never run short of dressings in here, the nurses are on the ball and follow the plan of care".

This meant that comments and complaints were listened to and acted on effectively.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

We looked at what the provider did to check the quality of the service, and to seek people's views about it.

We looked at the quality assurance file and saw copies of the 'manager's daily audit', which included a check of the home's communal areas and people's bedrooms, and whether any actions were required. We also saw copies of the 'night manager's checklist'. This included nightly safety checks such as whether staffing was appropriate, all doors and windows were locked and secure, staff were aware of what to do in case of fire, people had access to call bells, falls mats were in place and the nurse or senior member of staff in charge were up to date on people's needs or ill health.

We saw a copy of the provider's 'care home self-assessment tool', which was completed by the registered manager and based on the CQC five key questions. The registered manager graded each theme on a scale of one to five and provided evidence under each theme to support why the grade was awarded, as well as areas for development. For example, one area for development was regarding DoLS and stated, "Awaiting DoLS applications to be granted and once these have been received, specific care plans will need to be developed regarding the terms of the DoLS." The registered manager told us the frequency of this report depended on the rating and was verified by the provider.

We saw a copy of the most recent home visit report by the provider's operations director, dated 16 March 2015. This included a full walk around of the premises, feedback from people who used the service, relatives and staff, observations, the dining experience and any compliance issues.

We looked at the 'care plan audit matrix' and saw there were at least three audits per week. There were different audit templates for permanent residential people who used the service and those who were intermediate care. We also saw actions were in place when any issues were identified. For example, a bed rail risk assessment for one person said bed rails were not to be used. The action was for a consent form to be completed by the person who used the service. The audit said this was actioned on 14 February 2015. We checked the care records and found a copy of this consent form in the file.

We saw staff meetings took place monthly. We looked at the minutes for the meeting on 15 April 2015 and saw the agenda included taking a complaint, bedrails, fluid balance and diet charts, recording best interests, incontinence aids, paperwork and annual leave. We saw there were ten members of staff present at the meeting.

Staff told us the registered manager was, "Excellent" and "Provided good leadership". They also told us the registered manager was approachable if staff had individual problems and amenable if a member of staff needed to swap a shift. One care worker told us, "We feel supported and enjoy working here, where we are all members of a team. Another care worker told us, "I have been here five years now. I wish I had come into the care sector sooner, this is a lovely place to work."

We saw on the notice board that relatives, residents and friends meetings took place monthly and we saw people who used the service, friends and relatives had been consulted regarding changes made to the layout of the first floor of the building. The survey took place on 9 January 2015 and asked whether people thought it would have a positive, negative or no impact and were asked to include any additional comments. We saw people had also been asked what activities they attended and enjoyed and whether they had any suggestions for new activities.

This meant that the provider gathered information about the quality of their service from a variety of sources.