Primrose House Ltd

Primrose House

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

Summary of findings

Overall summary

This inspection took place on 4, 6 and 11 January 2016. The first day was unannounced.

This was the first inspection of this newly registered service. The service was called St Oswald's Care Home at the time of this inspection but has since been renamed Primrose House.

Primrose House is a care home for older people, some of whom have a dementia-related condition. It provides nursing care. It has 65 beds and had 43 people living there at the time of this inspection.

The service had a registered manager. 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 told us they felt the staff kept them safe and well-protected. People's relatives confirmed this. No-one expressed any concerns regarding people's safety. Risks to people were regularly assessed and appropriate measures were put in place to minimise any risks identified. There was a low level of accidents in the home. People were supported to take their medicines safely.

Staff had been trained to recognise and respond quickly to any abuse, neglect or poor practice. Safeguarding issues were reported to the appropriate authorities.

Regular checks were undertaken to ensure the building was safe. Systems and equipment were regularly serviced, and repairs were completed promptly. Plans were in place for dealing with any building or other emergencies.

Staffing levels were sufficient to meet people's needs safely and appropriately. People told us staff responded quickly when they needed them. Extra staff were provided when people's needs changed. Systems for recruiting new staff were robust and ensured only people fit to work with vulnerable people were employed. Staff were given the support they needed to perform their roles effectively, by means of regular supervision, training and annual appraisal.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. Where it was deemed necessary, written applications had been submitted to the local authority for authorisation to restrict people's liberty.

Appropriate assessments had been undertaken of people's capacity to make particular decisions. Where people lacked such capacity, appropriate 'best interest' decisions had been taken, with the involvement of the person's family, and these were clearly recorded. People were asked for their consent before staff

members carried out any care tasks or other interventions.

People's health care needs were closely monitored and were met using the support of a wide range of external health professionals. People's nutritional needs were assessed and they were supported to enjoy a varied and healthy diet.

People and their relatives told us the staff team was very caring, and treated them with sensitivity and respect at all times. We observed staff were attentive and responsive to people's needs, and affectionate in their approach. Staff were careful to protect people's privacy and dignity, and encouraged them to be as independent as they were able.

People were provided with information about their care and about the running of the home, were asked their views and could access advocacy services if needed.

When assessing people's needs, the views and preferences of the person and their family were sought and were included in the care plan drawn up to meet those needs. Care plans were kept under constant review and were updated as required. Meetings were held with people to discuss their care.

A range of social activities were available to people, and there were plans to increase the range of activities and other social stimulation, with more trips out.

The service was well managed. There was an open and reflective culture in which the people living or working in the home felt valued and respected. Staff morale was high: staff told us they enjoyed their work and were proud of the care they provided. People and staff commented very positively on the many improvements to the service over the previous year.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People told us they felt safe and protected in the home.

Staff had been trained to recognise and respond quickly to any abuse, neglect or poor practice.

Risks to people were regularly assessed and appropriate steps taken to guard against such risks.

There were sufficient staff to meet people's needs in a safe and timely manner. People were supported to take their medicines safely.

Is the service effective?

Good

The service was effective. The staff team was experienced and knowledgeable about people's needs.

Staff were supported by regular supervision and annual appraisal of their work. Staff had been given regular training.

People's rights under the Mental Capacity Act 2005 were understood and protected. People were asked to give their consent to their care and treatment.

People's health care needs, including nutritional needs, were met using the support of a wide range of external professionals.

Is the service caring?

Good

The service was caring. People spoke highly of the caring nature of the staff team.

People were provided with information about their care and about the running of the home, and could access advocacy services if needed.

Staff were careful to protect people's privacy and dignity, and encouraged them to be as independent as they were able.

Is the service responsive?

Good

The service was responsive. People told us staff responded quickly to any needs they expressed or any requests they made.

People's care was planned and given in a person-centred way, and respected the wishes and preferences of the individual.

The service was expanding the range and variety of the activities offered to people.

Complaints were taken seriously and responded to speedily and appropriately.

Is the service well-led?

Good

The service was well-led.

People, relatives, staff and professionals told us the registered manager had effected many changes for the better over the previous year.

There was an open and inclusive culture in the home, and the views of people, relatives and staff were sought and responded to.

Systems were in place for monitoring the quality of the services provided, and there was a commitment to the positive development of the home.

Primrose House

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 was 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 4, 6 and 11 January 2016. The inspection was unannounced.

The inspection team was made up of one adult social care inspector, a specialist nurse advisor 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.

We reviewed the information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as the local authority and Healthwatch to gain their experiences of the service. We received no information of concern from these agencies.

During the inspection we talked with 14 people and 12 relatives and other visitors. We spoke with 15 staff, including the registered manager, the provider's compliance support manager, an activities co-ordinator, two nurses, and care and ancillary staff. We asked the views of three visiting health professionals. We 'pathway tracked' the care of six people by looking at their care records, talking with them and with staff about their care. We reviewed a sample of four staff personnel files; and other records relating to the management of the service, including medicines, recruitment, staff supervision and appraisal, accidents and quality monitoring systems.

Good

Is the service safe?

Our findings

People told us they felt safe and secure in the home. One person told us, "I used to be very nervous at home, but I'm not nervous, now, I feel safe and protected." In a recent survey of the views of people and their relatives (November 2015, 30 respondents) conducted by the provider, all said they were happy with the security in the home. We asked all the relatives and visitors we spoke with if they ever had any concerns about anything in the home. No-one said they had ever had concerns, and all felt their relatives were safe and well-protected by the staff. One relative said, "When we take (name) out, they are always glad to be back here. They prefer to be here." A visiting social care professional commented, "I've never had any concerns with this home. There are no safety issues. People are well looked after." A health professional said, "I have no concerns at all. I have seen no poor practice."

The service had a policy and procedure on the safeguarding of vulnerable people. This policy was in line with local safeguarding authority and Department of Health guidance. Detailed records were kept of all safeguarding issues, which were also notified to the Care Quality Commission. Staff we spoke with were familiar with their responsibilities for recognising and reporting actual or potential abuse. Staff members were also fully aware of the service's 'whistle blowing' (exposing bad practice) policy, and assured us such practice would be immediately reported. The registered manager told us there had been no whistle blowing incidents in the previous twelve months.

People's human rights were recognised by the service, with specific reference to the Human Rights Act 1998 in the 'service user guide' given to people and their families. We saw evidence of people's rights being protected in various care records. Examples included giving a person protection from abusive relatives; accessing appropriate aids and equipment to enhance people's dignity and independence; and ensuring people's voices were clearly heard in decisions about their lives.

The service had a 'positive risk-taking' policy, which acknowledged that, for many people, taking some risks was an accepted part of life, and sought to balance people's safety with their need for independence. We found that risk assessments, where appropriate, were in place, as identified through the assessment and care planning process. This meant that risks had been identified and minimised to keep people safe. Risk assessments were proportionate and included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. Assessments also considered the likelihood of pressure ulcers developing or to ensure people were eating and drinking sufficient amounts. This meant that risks could be identified and action taken to reduce the risks and keep people safe. Standard supporting tools such as the Waterlow pressure ulcer risk assessment and the Malnutrition Universal Screening Tool were routinely used in the completion of individual risk assessments.

The safety of the premises was kept under constant review. Detailed maintenance and servicing records were available to show that checks and audits of the building and equipment safety were carried out regularly. Checks included the fire safety system and firefighting equipment, water quality, nurse call systems and window restrictors. Any necessary repairs were identified and carried out promptly.

Business continuity plans were in place to guide staff in responding to emergencies, such as services failure, fire, severe weather and contagious outbreaks. A plan for the relocation of people at short notice was up to date.

All accidents and incidents were logged in detail. We noted only one accident had been recorded since the service's registration in November 2015. We discussed this with the registered manager who told us this was due to having good staffing levels and very attentive and observant staff.

We checked the staffing rosters. These confirmed that staffing levels were adequate and appropriate, with two nurses, a senior care assistant, and seven care assistants during the day for 43 people, a nurse and five care assistants at night. We saw, in the pre-admission assessment of people's needs, a section which identified any additional factors that might require additional staff resources. Such factors included the need for one-to-one care, frequent observation or the use of specialist equipment requiring more than one staff member. The registered manager gave us examples of where extra staff had been provided to meet identified needs. They told us they always insisted on having adequate staffing, and that the new provider willingly provided the necessary resources. Staff told us they felt there was sufficient staff to meet people's needs safely, and people and relatives we asked confirmed this. A relative observed, "There's always plenty of staff on." In a recent survey of people's views, one person commented, "It's great seeing extra staff on the floor."

A comprehensive policy for the recruitment and selection of new staff was in place. This included application forms with full employment histories, declarations regarding fitness to work and any previous convictions, work references and proof of identity. Checks were carried out with the Disclosure and Barring Service to ensure the applicant was suitable for employment. The current provider had conducted an audit of existing staff recruitment documentation. This had identified some gaps in, for example, employment histories and missing interview records. The registered manager told us these deficits had since been addressed.

We looked at the way medicines were managed. Appropriate arrangements were in place for the administration, storage and disposal of medicines, including controlled drugs, which are medicines which may be at risk of misuse. Systems were in place to ensure that the medicines had been ordered, stored, administered, audited and reviewed appropriately. Medicines were securely stored in a locked treatment room and only the nurse on duty held the keys for the treatment room. Medicines were transported to people in a locked trolley when they were needed. The staff member checked people's medicines on the medicines administration record (MAR) and medicine label, prior to supporting them, to ensure they were getting the correct medicines.

Medicines were given from the container they were supplied in and we saw staff explain to people what medicine they were taking and why. The nurse gave people the support and time they needed when taking their medicines. People were offered a drink of water and the nurse checked that all medicines were taken.

We noted written guidance was not kept with the medicines administration records (MAR) charts, for the use of 'when required' medicines, and when and how these medicines should be administered to people who needed them, such as for pain relief. A staff member showed us that new documentation was currently being introduced and they reassured us that this would be implemented forthwith. We also noted inconsistent completion of topical medicines application records for two people to show the topical preparations people were prescribed, the instructions for use and associated body maps. However, the staff member was able to show us the new topical medicines application records that they were currently implementing.

Good

Is the service effective?

Our findings

People told us they felt their needs were met effectively. One person told us, "The staff here really look after me. I am very satisfied here." In a recent survey of the views of people and their relatives conducted by the provider, 96% said they were happy with the overall care in the home. A visiting health professional said, "The staff team definitely have the skills and knowledge they need. The nursing team are excellent."

The registered manager told us, "The staff team's knowledge of residents is extremely good. I have no qualms when care assistants need to brief health professionals, as they know their residents very well." The registered manager rated staff skills as, "Very good, generally", but also told us that staff knew there were areas such as dementia care where they required further development. Training in such areas was being given, and further training was planned to take place before the service opened a newly refurbished unit for people living with dementia-related conditions.

New staff members underwent a three day induction period during which they were supernumerary to the staff roster. During this period staff read and signed all the provider's policies and procedures, started their mandatory training, and shadowed experienced staff. An induction pack was also prepared for any agency staff used. The qualifications and registration of agency nurses was checked.

The registered manager was unable to access the staff training over the previous year as the previous provider had removed the computerised training records. However, staff training needs had been audited and we were shown a training plan that demonstrated a commitment to bringing all staff up to date by June 2016. Training was delivered by a combination of face to face training and e-learning. The registered manager told us staff were able to access computers on every floor of the home to undertake the e-learning and were paid to come in before their shifts to complete this.

Training in the month prior to this inspection had included food hygiene; infection control; fire safety; health and safety; safeguarding adults; equality and diversity; and dementia care. The registered manager told us senior care staff were studying for the level three Diploma in Clinical Health Care Support (QCF), to increase the skill base of the staff team. Other training booked included challenging behaviour awareness and management; and dementia awareness.

When asked about their recent training, a nurse told us, "I've had mandatory training and compression bandaging; and I'm due to do catheterisation, venepuncture (the process of obtaining intravenous access) and certification of deaths." A visiting professional told us, "Staff seem trained to understand people's needs." A second professional said, "The staff have good knowledge and skills."

Staff received regular supervision. We were shown the supervision planner which showed each staff member received one-to-one supervision every two months, and an annual appraisal of their work performance. This meant staff were given the support they needed to discuss their work, address any issues and identify their training and development needs. One member of staff told us, "I've had three or four supervisions lately. We discuss any issues, job wise." The registered manager was coming up to the end of their first year in post and

had plans in place for the annual appraisal of all staff.

Communication care plans were in place for people who used the service and we saw specific details for staff to follow in relation to how they engaged with people. One example of people's communication plans stated, "(Person) is only able to communicate by saying yes or smiling, can answer yes to simple questions, staff to always speak clearly and have patience and let (person) answer in any way they can." The individualised approach to people's needs meant that staff provided flexible and responsive care, recognising that people living with communication impairment could still live a happy and active life.

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.

Records confirmed that, where necessary, assessments had been undertaken of people's capacity to make particular decisions. These were decision-specific and stated that the assessment covered, for example, "medication, bed rails". We saw a record of best interest decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. This meant that the person's rights to make particular decisions had been upheld and their freedom to make decisions maximised, as unnecessary restrictions had not been placed on them.

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). Records showed that assessments had been undertaken to check whether people's care plan would amount to a deprivation of their liberty. Where it was deemed necessary, written applications had been submitted to the local authority for authorisation to restrict people's liberty.

The provider's policy on consent to care and treatment stressed the need for consent to be given voluntarily and freely, and that the person must be appropriately informed and have the capacity to give their consent. Staff told us they made a point of always asking people for their consent, and we observed this in practice during the inspection. People we asked confirmed this.

The initial needs assessment included the question, 'Is the person likely to upset or harm themselves or others?' Where such behaviours were identified, a specific care plan was drawn up to address the need, and episodes of distressed behaviours were recorded and analysed. Where appropriate, referrals were made to specialist behavioural teams. We observed a care assistant attending to a person who was distressed and calling out. The care assistant came and chatted to the person in soothing tones and very soon had distracted the person's attention and calmed them down. This was done very sensitively and in a caring manner.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition.

Where people were identified as being at risk of poor nutrition staff completed daily 'food and fluid balance' charts. The food charts used to record the amount of food a person was taking each day, accurately

documented the amount of food a person consumed. Fluid intake charts were completed, however there was inconsistency in the recording of fluid intake goals and completion of the totals. Indeed for one person we were unable to see a record of the subcutaneous fluids administered and the registered manager reassured us that they would address this.

People's weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health care professionals, such as GPs, dieticians and speech and language therapists, for advice and guidance to help identify any potential causes.

All the people we spoke with were complimentary about the food they received. They told us staff advised them of the menu 24 hours in advance of the meal and ask their preferences. People's comments included, "The food here is really lovely and you get a choice"; "You get good food here. I really like it"; and, "I really enjoy the food here."

People's records showed details of appointments with and visits by health and social care professionals. We saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example GPs, dietician, speech and language team (SALT), tissue viability nurses and the community psychiatric team. Care plans reflected the advice and guidance provided by external health and social care professionals. People received a visit from an Older Person's Nurse Specialist on the day of the inspection which we were told was part of their ongoing treatment and care plan. This demonstrated that staff worked with various healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met, to maintain their health and wellbeing.

We saw records of when people had made advanced decisions about receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' decisions for people. We saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form. Records also showed that the relevant people were involved in decisions about a person's end of life choices, in order to anticipate any emergency health problems.

Good

Is the service caring?

Our findings

People told us they were well cared for. One person told us, "The staff are great. It's beautiful here." A second person commented, "The staff are very helpful and caring. I am pleased to be here." Other comments included, "I like the staff and they like me. I'm treated with respect", and, "All the staff are absolutely brilliant. They do what I want."

A relative commented, "You could not get better than here. The staff are very friendly." A second relative told us, "The lasses here are smashing. We cannot find fault with anything. We brought (our relative) here for a week's respite and they were so well cared for, they insisted on staying on." Another relative said, "We chose this home after looking at three others. We are glad we did. Our (relative) came here from hospital with a huge bed sore on the ankle and leg. The care has been so good, here, it has completely gone. We are amazed at how well our (relative) is being treated here." A visiting professional told us, "All staff care about everybody." A second professional said, "The staff are very caring."

Staff demonstrated a commitment to people's care. They spoke warmly and knowledgeably about people as individuals and had a good understanding of the different ways people preferred their care to be given. They knew people's extended families and made them welcome in the home. Staff interactions with people were clearly based on respect and affection. One staff member told us, "The residents are the most important people in this home. Their well-being is our greatest concern." We noted a very friendly, relaxed atmosphere throughout the building. We saw, in the home's compliments file, the comment, "(Name) came in and you were strangers, but by the time (name) died, you were all friends."

The registered manager drew our attention to the service's 'mission statement', which stated, 'Our aim is to provide a quality of life we would expect for ourselves and our loved ones', and told us this was the principle by which the staff team operated.

The provider had a policy on equality and diversity and the 'service user guide' pledged, 'particular care will be taken to try to meet the needs of people from minority faiths.' The registered manager told us there were no members of minority ethnic or religious groups currently living in the service.

The service made efforts to give people the information they needed or wished about the service and their personal care arrangements. The registered manager held a meeting with relatives every six weeks. The average attendance, we were told, was about six relatives. Before the recent change of ownership of the service, a special meeting had been held to explain the changes, and more than 30 relatives attended. Letters had also been sent out regarding the changes. A 'welcome pack' of information was available to visitors in the entrance to the home. This included the last inspection report; a list of services such as hairdressing available to people; information about advocacy services; and safeguarding information. Policies were available in different languages and formats, upon request, and an 'easy read' pictorial complaints procedure was displayed on the notice board.

People's well-being was enhanced by services such as hairdressing, nail care and hand massages. People

were encouraged to personalise their rooms to their tastes and were able to access unlimited wi-fi. People's religious observance was supported and there were links with local churches. People's families and friends were able to visit without restriction, and were able to join them in meals, with notice. Advocacy support was available from two local advocacy services, and contact details of these were displayed in the home and given in the complaints procedure.

Policies were in place for maintaining the confidentiality of people's personal information and for data protection. The registered manager said that confidentiality was one of the core topics covered in induction, and they told us there had never been a problem with staff breaching confidentiality. People's privacy and dignity were also protected. We saw examples in people's care plans, including, "(Name)'s privacy and dignity is paramount", and, "(Name)'s privacy and dignity are to be maintained at all times." We saw people were able to request only a female or male care assistant for personal care tasks. Staff told us they paid attention to issues such as co-ordinated clothing and clean fingernails to maintain people's dignity. Bedroom and bathroom doors were closed when personal care was given, and visiting health professionals saw people only in their own rooms. However, we saw that people having their hair done by the visiting hairdresser had to sit in the corridor to have their hair dried. This was because there was no salon in the home and the hairdresser had to use a small bathroom. This was discussed with the new provider's representatives, who agreed this undermined people's privacy and dignity. They told us there were plans to convert another room into a salon.

People were encouraged and supported to be as independent as they were able. People's abilities and skills were acknowledged in their care plans, as well as their needs. We saw examples in care plans such as, "(Name) is able to wash their face, hands and upper body when given a soapy face cloth and towel", and, "Staff support (name) with personal hygiene, allowing them to carry out tasks they can do for themselves like washing and drying hands and face." The registered manager told us, "The issue of independence is constantly under review. We have a positive approach to risk taking, and we involve the person in getting the right balance between risk and independence."

People's wishes regarding their end of life care were ascertained as part of their assessment. A 'palliative and end of life care' section of the assessment recorded any advanced decisions the person had made, such as whether or not to resuscitated, and included the person's capacity to make such decisions. The registered manager told us he and eight staff members had undergone levels two and three of a distance learning course on end of life care. Facilities were available if family members wished to stay in the home with their loved one at the end of a person's life, and MacMillan cancer care nurses were accessed via the person's GP, where appropriate. No one living in the home was at this stage of their lives at the time of this inspection.

Good

Is the service responsive?

Our findings

People told us staff responded quickly when they needed them, and carried out any requests. One person told us, "You never have to wait long for the girls, and they will do anything for you." In a recent survey of the views of people and their relatives conducted by the provider, 87% said staff carried out requests in a timely manner and to a level the person wished. A visiting professional said, "The nurses are always quite responsive." Another professional commented, "They carry out whatever ask I them to do." A third professional told us, "The manager listens and responds. They deal with any issues."

A care plan for people's individual daily needs such as mobility, personal hygiene, nutrition and health care was written using the results of the dependency and risk assessments carried out. Staff knew the individual care and support needs of people, as they provided the day to day support and this was reflected in people's care plans. The care plans gave staff specific information about how the person's care needs were to be met and gave instructions for frequency of interventions and what staff needed to do to deliver the care. The care plans were regularly reviewed to ensure people's needs were met and relevant changes were added to individual care plans. We noted that not all care plans were clearly person-centred. The registered manager told us this had been identified, and all care plans were being re-written to better reflect people's needs and wishes.

There were clear plans in place that illustrated strategies to be followed and how verbal or physical aggression towards objects or people should be handled. Care plans gave staff clear guidance about what actions they should take when the person became agitated and upset. This helped ensure that staff responded consistently and that people's family and professionals were informed. These plans were regularly reviewed and where people displayed distressed behaviour, showing agitation or distress, they were referred to the behavioural team for advice and specialist support. We saw this advice was incorporated in people's behavioural plans to help staff provide care to the person. One example stated, "Staff are to play relaxing music CD prior to any intervention, approach (person) and introduce themselves whilst placing their hand on theirs to reinforce their presence, talk in a respectful, assertive but non-threatening manner, should give (person) something to hold this may prevent scratching or grabbing."

The service used a 'Transfer to hospital or other care home' form to ensure essential information about the person and their care needs was shared with the new service. Information included all recent input from external professionals regarding the person's current health, past medical history, medicine administration record, description of needs and abilities and a body map.

Reviews of the person's care were carried out six weeks after admission, to confirm the suitability of the placement, and at least every six months, thereafter.

The service was in the process of developing a 'dementia strategy'. The currently empty top floor of the service was being refurbished as a specialist dementia care unit, and would be opened when new staff had been recruited and trained.

A weekly activities programme was displayed around the home. We found this to be repetitive and lacking in imaginative pastimes. The registered manager accepted this and showed us the new provider's action plan to improve the range of social activities and other social stimulation, including trips out. As a demonstration of this commitment, a second activities co-ordinator had just been employed, doubling the hours available to lead activities, and the social programme was being reviewed and revised. Visiting entertainers were booked once per month and outside activities took place in good weather. Birthdays and other special occasions were celebrated in the home, and a hairdresser visited the home weekly. We saw people's social histories were being compiled, but the details of these had yet to be included in people's social care plans.

Individual choice was demonstrated in people's care plans. These showed people had freedom of choice about when they got up and went to bed, what they wore, what they ate, and how they spent their day. Examples seen included, "(Name) chooses all clothing they wear"; "Prefers bath to shower"; and, "Only likes to wear skirts."

The service's complaints procedure was prominently displayed in the home. An appropriate format was used to record complaints and concerns, with details of the complaint, actions taken to investigate and rectify the issue, and the complainant's satisfaction with the outcome. We saw two complaints had been logged in recent months. Both had been fully investigated, with appropriate actions taken and written apologies made. We asked visiting relatives if they knew how to complain. They all told us they knew how to complain but said they did not feel the need to make formal complaints. Several said that the manager was very approachable.

Good

Is the service well-led?

Our findings

The service had a very experienced registered manager, who had been in post for eleven months. They were fully aware of their responsibilities under their registration and notified us of relevant issues. The registered manager was familiar with the requirements of the new 'duty of candour'. This duty requires registered people to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong. The registered manager reported very good support from the new provider. They told us, "It's gone from very little support to excellent support." They told us they were being given the resources to develop the service.

People told us they were happy with the management of the home. One person told us, "The manager is very good, and listens to what I say." A visiting social care professional commented, "This is a well-managed home. My client and their family are very happy with the service." A health professional told us, "Things are better since the new manager has been in. Although it is still transitioning, there's more consistency for staff, and more continuity. They have had the whole building redecorated, and they encourage staff to do more training." A third professional said, "This is a well-organised and well-managed home."

We asked staff about the management of the service, and whether they felt supported and listened to by the registered manager. Staff told us they were very satisfied with the way the service was managed. One staff member told us, "We are very well supported and listened to. The manager is a very approachable person, they're pretty good to be honest." A second staff member told us, "The manager is great, very approachable, accommodating and understanding, wants our views and responds to suggestions." Staff also said the registered manager was clear in their expectations of the staff, had introduced more clarity and structure and modelled good practice.

Staff told us morale was high, as they felt there had been many changes for the better over the past year. They said they were proud of their work. One staff member commented, "The carers are brilliant with residents, they're very hard working, caring, lots of patience and they know people really well."

We found there was a culture of openness in the service. People, relatives and staff felt able to express themselves without fear, and felt valued by the service. In a recent survey of the views of people and their relatives conducted by the provider, 100% said the registered manager was approachable. People's opinions were sought and acted upon. For example, in the course of this inspection, a relative raised a concern about an environmental issue affecting their relative. We saw this was responded to immediately, and resolved by the next day.

Links with the local community were being developed. Particular links were being forged with the local community centre, where people living in the home could visit for coffee mornings, tea dances and other activities. The registered manager had also contacted local schools and churches to foster good relationships.

A range of quality auditing systems were in place to monitor the performance of the service. At the time of

the service being registered in November 2015, the current provider had carried out a full audit of policies and procedures, systems, records, care and management practices, administration, staffing levels and activities. The provider had identified where improvements were required and had drawn up a detailed action plan, with dates for completion. This was still in the process of being worked through, with the registered manager updating the plan as actions were completed. Improvements noted to date included revised policies and procedures, improved channels of communication with people and staff, and new care record formats being introduced.

Internal audits were carried out by the registered manager. These included quarterly audits of catering and infection control, and monthly audits of care records, medicines administration, nutrition, accidents and incidents. In addition, there were regular inspections of the service by the provider's compliance support officer.

A survey of the views of people and their relatives was conducted by the provider in November 2015. Actions had been taken to address issues and concerns raised by this survey. These included a refurbishment of the building, the provision of new bedding, improving the activities programme, responding to requests regarding food and drink, and focussing on privacy and dignity issues.

The service was in the process of transferring information from the previous provider's system of documentation to its own formats. This had led to some duplication of information and some omissions, especially as the previous provider had not allowed computerised records to be passed over. However, the experience of visiting health and social care professionals was that staff could provide the necessary information promptly, when requested. One professional told us, "Staff know their residents, know their histories. Staff handovers are good, there's good continuity of care." The registered manager told us extra staff and support was being given to ensure the transfer of information was as smooth as possible.