Objectquest Limited

Bethany House Care Home

Inspection report

Village Close
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Newton Aycliffe
County Durham
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Tel: 01325300950

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15 December 2015

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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

The inspection took place on 14 and 15 December 2015 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Bethany House Care Home on 20 January 2014, at which time the service was compliant with all regulatory standards.

Bethany House Care Home is a residential home in Newton Aycliffe providing accommodation and nursing care for up to 31 people who require nursing and personal care. There were 31 people using the service at the time of our inspection.

The service 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.

We found that there were adequate numbers of staff on duty in order to meet the needs of people using the service.

Safeguarding principles, types of abuse to look out for and relevant contact information should people who used the service, relatives or staff have concerns were clearly displayed throughout the service. Members of staff displayed a good knowledge of safeguarding issues and a clear understanding of warning signs to be mindful of and their prospective actions should they have such concerns

We saw risks to people were managed through risk assessments and associated care plans. These risks were reviewed each month and we saw when relevant information was provided by healthcare professionals this was incorporated into care planning and risk assessment.

We found the service had systems in place for ordering, receiving, storing and disposing of medicines, including controlled drugs. Administration of medicines was generally safe and adhered to the National Institute for Health and Clinical Excellence (NICE) guidelines.

There were effective pre-employment checks of staff in place, including Disclosure and Barring Service checks, references and identity checks, whilst records of interviews were detailed and specific to the role.

The service was clean throughout, with a range of infection control measures in place, including two domestic assistants on duty at the time of inspection.

Training was relevant to people's needs, with staff having completed communication training recently to help support their engagement with people who could not verbalise their wishes. Other recently completed

training included: dementia awareness, infection control, manual handling, first aid, person-centred care, safeguarding, death, dying and bereavement, equality, diversity and inclusion and medicines administration. When we questioned staff about the practicalities of a range of these areas, they were able to give detailed and informed answers.

Staff had a good knowledge of people's likes, dislikes and life histories and built a rapport with the people they cared for. This was facilitated by a key worker system, whereby staff had responsibility for individuals, leading to trusting relationships and a greater continuity of care.

Staff were well supported through formal supervision and appraisal processes as well as ad hoc support when required.

People had choices at each meal as well as being offered alternatives if they did not want the planned meal options. People told us they enjoyed the food and we observed calm and attentive interactions between staff and people they supported during lunchtime. We saw the service had successfully implemented a tool to manage the risk of malnutrition. The service's approach to supporting people who required specialised diets was praised by a dietitian.

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 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).

We checked whether the service was working within the principles of the MCA. The registered manager displayed a sound understanding of capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

The atmosphere at the home was welcoming and vibrant, with people engaged in activities that were meaningful to them, such as visiting the nearby day centre or watching films, and engaging in warm interactions with staff. Relatives and external stakeholders agreed that staff were caring and compassionate.

Extensive person-centred care plans were in place and daily notes were accurate and contemporaneous. Regular reviews ensured relatives and healthcare professionals were involved in ensuring people's medical, personal, social and nutritional needs were met.

People's religious beliefs were respected and encouraged. A local church regularly held services in the home, whilst also providing befriending support. The service had built and maintained strong community links, with the church, a day centre and educational establishments, from which students regularly attended on work experience placements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff displayed a good understanding of safeguarding principles and relevant safeguarding contact information was clearly displayed.

Risks to people were individually assessed and associated care plans updated accordingly in order to mitigate risks.

The service had systems in place for ordering, receiving, storing and disposing of medicines, including controlled drugs. Administration of medicines was generally safe and adhered to the National Institute for Health and Clinical Excellence (NICE) guidelines.

Is the service effective?

Good

The service was effective.

A range of training the service considered mandatory was in place, as well as more specific training tailored to the needs of people who used the service.

The registered manager displayed a sound understanding of capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

People told us they enjoyed meals and the risk of weight loss was managed through dietitian involvement.

Recent and ongoing improvements to the premises were undertaken with the needs of people who used the service in mind.

Is the service caring?

Good

The service was caring.

The atmosphere at the home was welcoming and vibrant, with relatives and external stakeholders in agreement that staff were

caring and compassionate.

Care plans acknowledged and incorporated people's preference and voices to ensure the care delivered involved them.

People's religious needs and preferences were respected.

Is the service responsive?

Good

The service was responsive.

The service had in place a range of activities, which included regular group activities and more bespoke activities for individuals.

Regular feedback was routinely sought from people who used the service through residents' meetings and questionnaires in order to help plan activities.

Complaints were managed, monitored and responded to consistently, with people who used the service and their relatives aware of who to complain to if they had concerns.

Is the service well-led?

Good

The service was well-led.

The service had built and maintained strong community links with a church, a day centre and educational establishments, from which students regularly attended on work experience placements.

Quality assurance and auditing work was supported by dedicated resource and an IT system that facilitated detailed and regular reporting on aspects of the service.

The culture of the service was efficient and geared toward the wellbeing and needs of people who used the service.

Bethany House Care Home

Detailed findings

Background to this inspection

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

We visited the service on 14 and 15 December 2015 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one Specialist Advisor. A Specialist Advisor is someone who has professional experience of this type of care service, in this case nursing.

We spent time observing people in the communal areas of the home. We spoke with five people who used the service and seven relatives of people who used the service. We spoke with eleven members of staff: the registered manager, two nurses, four members of care staff, the activities co-ordinator, the cook and the laundry manager. We spoke with a visiting nurse, a visiting physiotherapist and a visiting dietitian as well as telephoning two social care professionals on the following day.
During the inspection visit we looked at nine people's care plans, risk assessments, six staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and returned to CQC prior to the inspection and we used this information to inform our inspection.

Good

Is the service safe?

Our findings

People who used the service, relatives and external healthcare professionals agreed that the service provided care in a safe manner. One person who used the service said, "No concerns." One relative told us, "I've never had any concerns and I come in every day."

We saw safeguarding policies were comprehensive and had been reviewed recently to incorporate newly defined aspects of abuse such as self-neglect. Safeguarding principles, types of abuse to look out for and relevant contact information should people who used the service, relatives or staff have concerns were clearly displayed throughout the service. When we spoke with members of staff about their knowledge of safeguarding issues they had a clear understanding of warning signs to be mindful of and their prospective actions should they have such concerns.

We reviewed a range of staff records and saw that in all of them pre-employment checks including enhanced Disclosure and Barring Service checks had been made. The Disclosure and Barring Service maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We also saw the registered manager had asked for at least two references, verified these references by telephone and ensured proof of identity was provided by prospective employees' prior to employment. Interview records we saw were comprehensive and detailed the discussion had about prospective members' of staff's suitability to the post. This meant that the service had in place a robust and consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

We saw that individual risks were managed through risk assessments that were regularly reviewed and updated, with relevant information transferred into care plans. Risk assessments were tailored to people's individual needs and effectively managed the risks identified. For example, one person's risk of falls was regularly monitored. Mitigating actions included a move to a room that presented fewer risks of trips due to its location, as well as updates to this person's communication plan to ensure staff were better able to communicate with them and understand their mobility needs. This meant the service had a structured approach to reviewing individual risks and managed those risks in a person-centred way.

The majority of people we spoke with felt staffing levels were adequate and during our inspection we saw call bells were answered promptly and people were not put at risk due to understaffing. There were sufficient staff on duty to meet the needs of people and we saw staffing levels had been calculated using a recognised dependency tool. There was a consensus amongst staff and relatives we spoke with that, whilst staff were sometimes extremely busy, staffing levels were adequate. Six staff members we spoke with, when asked what would make the service better, stated, "More staff," although they acknowledged that people's needs were not neglected. One member of staff said, "I feel we have enough staff – you can never predict what's going to happen so sometimes it's a bit rushed but we have enough." Another member of staff said, "To improve things I would employ more staff, not that we are understaffed but it would free us up to give more one to one quality attention." One relative we spoke with stated that service was regularly short of staff but there was no evidence of people's needs not being met through neglect. This meant people using

the service were not put at risk due to understaffing.

We found the service had systems in place for ordering, receiving, storing and disposing of medicines. We looked at how the service managed controlled medicines and found that safe storage, administration and recording was maintained. The medicine store room we observed, which doubled as an office, was secure, clean and organised, whilst room and fridge temperatures were checked daily and showed medicines were stored at a safe temperature.

We looked in detail at people's Medicine Administration Records (MARs) and found these to be generally sound, with one error noted and raised with the nurse on duty. They displayed a good knowledge of the drug in question, how it may have been missed from the MAR and were able to give assurances about the standards of medicines management more generally. They undertook to ensure instances of medicines being refused were always appropriately documented. Other members of staff we spoke with also displayed a good knowledge of medicines administration and we saw their competence was regularly assessed.

The nurse on duty demonstrated a good understanding of people's needs and pain relief regimes and we saw care plans contained detailed information about how and when people might indicate they required additional 'as and when' medicine, for example when people were unable to verbalise they were in pain. We observed medicines being administered in line with the National Institute for Health and Clinical Excellence (NICE) guidelines and saw safe practice was maintained throughout. The nurse communicated effectively, giving people time to understand the medicines they were being given. We saw explanations were given and consent was sought at each stage.

We saw falls and incidents were recorded and archived in a manner that allowed for rigorous analysis of them to identify any trends and patterns. We saw this had regularly happened. This meant the service used the information technology available to it to monitor incidents across the service to ensure any emerging risks were identified.

The risk of acquired infection was well managed through training, group supervisions and signage. Awareness of the risks of infection were built into relevant care plans. For example, we saw catheter care plans contained detailed descriptions of the warning signs of infection to be aware of, and how to mitigate and manage these risks. A recent visit by the infection control team had identified a small number of areas to improve and we saw the relevant actions had been taken, with the outcomes of this visit communicated to staff through a group supervision. We saw the service had on shift two domestic assistants and one bed-maker and we found all communal areas, bathrooms and bedrooms we saw to be clean. One relative said, "It's always clean here and there is never a smell." The Food Standard Agency (FSA) had given the kitchen in the home a 5 out of 5 hygiene rating, meaning food hygiene standards were, "Very good." This meant people were protected from the risk of acquired infections.

With regard to potential emergencies, we saw that Personalised Emergency Evacuation Plans (PEEPs) were in place and easily accessible to anyone needing to support people to leave the building in an emergency. We noted that these were not accompanied by people's photographs and the registered manager agreed to consider doing this.

We saw the service had recently installed CCTV cameras to external and communal areas of the home, following discussion with people who used the service. People and their relatives told us they had no objections to the cameras and the registered manager was able to tell us about examples when CCTV footage had been used to establish facts following a recent alleged incident.

With regard to the maintenance of premises, we saw Portable Appliance Testing (PAT) had recently been undertaken, whilst all hoisting equipment and lifts had been serviced recently.

We saw wheelchairs were serviced regularly with necessary repairs made. There was documentation evidencing the servicing of the gas boiler. We saw that fire extinguishers had been checked recently, fire maintenance checks were in date and the nurse call bell systems were regularly tested and serviced. We saw the registered manager also undertook a twice-daily 'walk around audit', which served to identify any aspects on the premises in need of repair. This meant people were prevented from undue risk through poor maintenance and upkeep of systems within the service.

Good

Is the service effective?

Our findings

All staff we spoke with felt appropriately supported to carry out their role and we saw training was delivered throughout the induction period and regularly thereafter. Training the provider considered mandatory included Dignity and Respect, Moving and Handling, Safeguarding Adults, Mental Capacity Awareness, Food Hygiene, Wheelchair Safety Awareness, Basic Emergency First Aid and Risk Assessment. We also saw additional training was provided where relevant to people's needs, for example Dysphagia, Epilepsy Awareness, End of Life Care, Catheterisation and Communication training.

Staff we spoke with were able to talk about their learning in depth and how they were able to more effectively understand the needs of people who were unable to communicate verbally by identifying non-verbal prompts. We observed patient and attentive interactions during our visit between staff and people who could not communicate verbally and, when we look at people's respective care plans, saw there was detailed information regarding how they liked to be communicated with and how staff could support them. Training was planned on a training matrix which contained details for every member of staff regarding training they had completed or were yet to complete, as well as relevant renewal dates. This meant staff had the knowledge and skills to carry out their role and provide high levels of care to people using the service.

We saw staff supervisions occurred regularly along with annual appraisals. Group supervisions also occurred on an ad hoc basis when a specific or immediate message needed to be communicated with all staff, for example changes brought about following an infection control team visit. All staff we spoke with, both established members of staff and recent starters, were positive about the support received through these meetings and told us they had ample opportunity to identify any training needs or concerns. One said, "I'm enjoying my time here and am gaining more experience and understanding of processes." Another told us, "My appraisal and supervision are up to date with the manager. We have the training, systems and equipment in place and residents enjoy a family feel to the home." This meant people could be assured they were cared for by staff who were adequately trained.

We saw people were supported to maintain their health through accessing external healthcare services such as opticians, dentists, dietitians, physiotherapists, speech and language therapy, District Nurse and GP visits. All external healthcare professionals we spoke with were positive in their opinions of the levels of person-specific knowledge and information staff presented them with. Similarly, people who used the service and their relatives were for the most part confident in the capability of staff. One relative stated, "They support complex needs – I was a bit apprehensive at first but they manage the mix of people really well," and another, "They're aware of [person's] non-verbal quirks." People who used the service and their relatives were similarly confident in the knowledge and experience of staff. One person who used the service told us, "The staff are excellent," whilst one relative said, "The carers are consistent and reliable in their approach." Another said, "They know to turn [person] regularly and make sure they don't develop any sores."

With regard to nutrition we saw all staff had been trained in Focus Under Nutrition and were implementing the Malnutrition Universal Screening Tool (MUST) tool. MUST is a screening tool using people's weight and

height to identify those at risk of malnutrition. Focus on Under Nutrition is an accredited training scheme designed to improve staff awareness of the risks of under nutrition and equip them to manage this risk. Kitchen staff were aware of people who required specialised diets and we saw the service involved external healthcare professionals such as dietitians and Speech and Language Therapy (SALT). One professional praised the service's, "Food first" approach when supporting people requiring fortified diets due to the risk of weight loss. They described staff as, "Responsive and always alert."

We observed lunch in the main dining area to be calm, with patient and attentive assistance offered by staff to people who required support. We observed displays of affection and humour where appropriate. One person told us, "The food is lovely and the staff so very kind." Another person told us, "The food is good and you can ask for what you want."

One relative raised concerns about the lack of focus on hydration, suggesting more could be done to ensure people stay hydrated, such as having a trolley of drinks constantly available for people. During our inspection we saw cups of tea and other refreshments were regularly offered from a trolley that was taken via all people who used the service.

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 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).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager and staff we spoke with demonstrated a good understanding of Mental Capacity issues, including DoLS. We saw detailed and informed rationales behind capacity assessment outcomes and saw appropriate documentation had been submitted to the local authority regarding the DoLS.

With regard to the premises, the building met the needs of people who used the service through the design of the building. For example, all rooms had a ceiling hoist to ensure people with mobility needs could access all areas. 16 rooms had en suite facilities. Macerators had recently been installed in the sluice and we saw these had reduced the need for transferring waste, saving staff time. We saw planning permission had been received for an additional lift to ensure that moving between floors was easier for people who used the service. We also saw additional storage space had recently been built, meaning the service would be able to ensure corridors remained clear and uncluttered. The service had recently purchased a minibus to increase the opportunities for people who used the service to go on outings (the previous bus had space for three wheelchairs). The service also had a van which was insured for any driver, meaning family members could use the van to take a person who used the service out for the day. We saw evidence of this happening regularly. One relative stated the service was regularly cold but we found no evidence of this during our inspection, with all communal areas and private room an appropriate temperature. This meant the premises and other facilities were tailored to be useful for the people who used the service.

Good

Is the service caring?

Our findings

Care plans we saw were detailed and involved the person's wishes to tailor aspects of care. For example, one person had in place a pain management plan, which detailed all aspects of medicines related tasks. The plan also stated, "A little chat and some time spent with me will often help me feel better." We saw another care plan had detailed information regarding one person's shaving regime and how they liked to be supported to shave with hand-over hand support, to ensure they were safe but also involved in their own care. This meant the service had regard to people's dignity and willingness to remain independent. It also meant the service's care plans were not limited to the completion and delivery of tasks but ensured the person's voice was heard and acted on.

The caring and dedicated attitude of staff was a consistent theme when we spoke with people who used the service, relatives and external healthcare professionals. One person told us, "This is my home, I could not be more happy – staff are excellent." One relative told us, "The staff are brilliant," whilst another said, "I would always recommend it. The staff are fun, not stern and it's like one big family. There is a real bond."

We also reviewed a range of thank-you cards which consistently described a positive caring environment: "All of the staff have been excellent"; "I would like to thank you all for the kindness"; and "Thank you for treating [person] with so much care, compassion and dignity." The range of evidence we gathered corresponded to interactions we observed throughout the inspection, with care staff regularly sharing jokes that were meaningful to people who used the service.

The comprehensive nature of care plans meant staff had the relevant background and current information regarding a person's care needs before supporting them. The service also used a keyworker system, meaning people who used the service received care from a small number of staff, improving their continuity of care but also their opportunity to build a rapport with those members of staff.

Preserving and maintaining dignity and individuality were noted as key goals in the Service User Guide and we saw this in practice. For example, where care plans identified risks to people's health, they also had regard to any related impacts on dignity. Care plans supporting one aspect of people's personal care needs were particularly thought-through in this respect. We saw people were treated patiently and as individuals. For example, when, due to being bedbound, one person was unable to attend a DVD screening in the lounge of a recent activity, the activities co-ordinator sat with the person in their room and watched the DVD with them. All service user questionnaire responses confirmed staff were courteous and respectful, as well as upholding people's right to dignity and choice. This meant the service cared for people in a manner that respected and upheld their dignity.

We also saw on one occasion the service had been contacted by social workers regarding a person requiring emergency support and had provided them with a hot meal. The social care professional stated, "Your prompt response and assistance needs to be acknowledged and I fully recognise the value of having a supportive community to work in."

We saw religious beliefs (as well as atheism) were respected and that people had advanced care plans in place where they chose. Relatives we spoke with told us they had been involved in all aspects of the process and that the person's wishes regarding where they preferred to end their life and their funeral arrangements were respected. We saw people who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place had been involved in the decision, as had family members and local medical professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. We saw that people with a DNACPR in place had this reviewed regularly.

We saw that staff had signed a confidentiality agreement when they were employed by the service and that people's sensitive personal information was stored securely on an IT system which was password protected.

A number of relatives we spoke with visited at different hours of the day and confirmed there were no limitations on their visiting times. This meant people using the service and their families felt more able to consider the service a home and were not restricted in their visiting hours.

We saw that information regarding advocacy services was readily available in the Service User Guide and the registered manager had a good understanding of formal and informal advocacy.

Good

Is the service responsive?

Our findings

We found the service provided healthcare and activities that were responsive to the individual needs and preferences of people who used the service. Pre-admission assessments were undertaken to ensure the service had detailed information regarding people's health needs, likes, dislikes and personal history. This information was then incorporated into individual care plans and risk assessments for each person, which were stored electronically on the service's database and regularly reviewed. We found care records to be detailed, accurate and contemporaneous.

Care plans were comprehensive, person-centred, took account of people's likes, dislikes, personal preferences and gave people a voice. Daily notes and records of care were similarly comprehensive and informed by a pre-assessment document that included the person's photograph, medical history and immediate risks.

Care plans and risk assessments we viewed were all reviewed recently and we saw that when people's needs changed relevant care plans, along with any associated risk assessments, were updated. When we spoke with relatives the majority confirmed they were invited to be involved in care plan reviews and that the service kept them informed of changes. For example, one person was noted as presenting more challenging behaviours. A seven-point care plan was put in place with such actions as additional GP involvement and the means by which staff could more meaningfully build a rapport with the person through their communicative style. This had regard to the person's history and the conversation topics that were known to be calming. Associated care plans were also updated with this information in mind. For example, a personal hygiene care plan had been amended to ensure instructions to staff incorporated aspects of how best to minimise the person's potentially challenging behaviours. As a result of these changes we saw the person had recently exhibited less aggressive behaviours.

One relative expressed concerns about levels of responsiveness within the service but the consensus from people who used the service, relatives and external healthcare professionals, along with the evidence in individual care plans, was that changing individual needs were appropriately supported. External healthcare professionals told us, "The staff here are responsive and always alert us to any difficulty or challenge they encounter," "Residents are well looked after."

The service provided and enabled a range of activities that were informed by people's interests and histories. Some activities were discussed at regular resident meetings and details of upcoming events were shared with people through a monthly newsletter, as well as posters in the corridor. Individual preferences were noted and acted upon, for example one person stated how they enjoyed taking pride in their appearance and would like to visit the hairdresser weekly. We saw this was in place. Likewise, group preferences were listened to and acted on. For example, animal-related activities had proved the most popular during a recent survey and we saw the service had planned in more animal visits and activities.

Recent activities, facilitated by the full time activities co-ordinator, included visits by a pony and a poodle, birthday celebrations, films, hairdressing, bingo, sing-a-longs, armchair exercises twice-weekly, church

services and one-to-one time. People who used the service confirmed they were supported by way of one-to-one visits from staff. The service had access to a nearby day centre, where some of the activities were held and were a local dance troupe met. We saw discussions had taken place to arrange for the dance troupe to perform in the home for people who used the service. We saw regular outings were arranged. One relative told us that their family member had moved into the service and the transition had been managed, "Really well." They said, "It's been good so far – it's very relaxed and on [person's] second day they went to a garden centre to see the Christmas lights; they loved it."

We saw the service had a complaints policy in place and corresponding information was available in the Service User Guide, as well as readily available in public areas. People and relatives we spoke with were aware of how to make a complaint. We reviewed a number of complaints and found them to have been handled in line with the service's policy and in a detailed manner that addressed all aspects raised by the complainant. We also saw the service regularly produced a report which gave an overview of all complaints to establish whether there was a trend of a certain complaint type.

The service helped to protect against social isolation through an over-arching activities programme as well as one-to-one time spent with people where that was their preference.

Good

Is the service well-led?

Our findings

The registered manager had relevant experience in health and social care and a sound knowledge of the day-to-day workings of the service. One relative stated, "Management say they'll get things done but they often don't," but we found a consensus of evidence that the management of the service ensured people received safe and effective care. One person who used the service described the manager as, "Lovely," whilst a relative said, "The manager is on the ball and approachable." One healthcare professional we spoke with stated, "The manager is very knowledgeable and is always quick to sort things out." All other external healthcare professionals we spoke with confirmed the atmosphere and culture of the home was welcoming and open, whilst staff spoke of positive levels of support and leadership they received from management. The registered manager is responsible for ensuring the culture of the service is in line with its Statement of Purpose and geared towards the needs of people who used the service; we found this to be the case.

The manager was able to talk in detail about the specific care needs of a range of people who used the service and demonstrate how IT systems were used to support a more efficient approach to quality assurance, accountability and auditing. We saw evidence the registered manager communicated key messages effectively, such as outcomes from infection control visits, through a range of forums such as group supervisions and team meetings.

The IT system allowed for reports to be generated regarding a number of different comparable fields (for example, all complaints in a given period, all care plan reviews over a given period, or a printout of all nurse call bells triggered and responded to). This meant the service was able to access and interrogate information relevant to the safety and quality of people's care in an efficient and consistent fashion. We saw care plan audits were undertaken regularly, with a target of one per day, meaning that all people who used the service had their care needs monitored by someone other than immediate care staff on a monthly basis (the service was registered to provide care for up to 31 people). The majority of auditing was undertaken by the registered manager, the deputy manager and a Registered General Nurse. Both the registered manager and the deputy manager were also registered nurses. We saw they were supported to complete administrative duties by a part time office assistant with nursing experience. This meant those with the responsibility for overseeing care standards had the relevant experience.

Audits undertaken included staff attire, mattress checks, sluice room and care plan audits. We saw actions were taken where an audit identified the need for improvement. For example, mattress checks were previously held in the manager's office but had recently been moved to respective cleaning cupboards, making the process more efficient.

We also saw the Managing Director visited the service every two months, talking with different people who used the service and staff and undertaking a sight-check of the premises to see if there were other areas the service could improve, through their observations or through the feedback gathered.

We looked at the minutes of meetings held by the trustees of the charity and found there to be a

commitment to the further improvement of the standard of care given by the service, in line with the discussions we had with the registered manager. For example, the service had recently purchased a new minibus and was in the process of planning the installation of a new lift.

We saw the service undertook regular staff and resident questionnaires to gather feedback about the standard of care provided and where general or specific improvements could be made.

We found the culture of the service to be focussed, respecting and promoting people's dignity. Staff took pride in this and all we spoke with described a sense of achievement and purpose through providing care. One staff member said, "The best things is the family style atmosphere, very low turnover and pulling together make work a pleasure." Another said, "The best thing about working here is going home knowing you have made a difference; each person matters."

We saw evidence of an openness from management, particularly with regard to responses to formal complaints, which were comprehensively addressed. One also told us, "[Registered manager] always tells us about the outcomes of inspections – they keep us in the loop." This meant the registered manager was aware of their responsibilities with regard to sharing the outcomes of CQC inspections with people who used the service and their relatives.

During the inspection we asked for a variety of documents to be made accessible to us. These were either easily accessible on the computer system or promptly provided in paper format, for example hard copies of care plans where people's signatures were required. We saw documents were regularly reviewed and updated in line with current thinking and legislation. For example the safeguarding vulnerable adults policy had been updated to include recently included definitions of abuse. We found records, whether individual care plans or policy documents, to be well kept, easily accessible, accurate and contemporaneous.

The registered manager had established and maintained strong links with the local community. For example, the home hosted a church service four times a year, with people who used the service and members of the community attending. Befrienders from this local church also visited the service once a week to chat to people who used the service. There were also strong links with the nearby day centre, whose facilities people who used the service regularly accessed for activities. The service had also successfully hosted student nurses and students hoping to pursue a career in social care. Responses we saw from students indicated they had gained knowledge and found the experience to be a positive one. We also saw the service welcomed a volunteer on a weekly basis who spent time chatting with residents. This volunteer had previously nursing and hospice experience. Such links ensured people who used the service had the opportunity to remain engaged with their community and also that members of the community of various generations maintained a link with people who used the service.