Mr James Douglas Ford

Hook Hall High Street

Inspection report

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Goole
East Yorkshire
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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 8 December 2015 and was unannounced. We previously visited the service in November 2013 and we found that the registered provider met the regulations we assessed.

The service is registered to provide accommodation for up to 21 people who require assistance with personal care. On the day of the inspection there were 15 people living at the home. The home is situated in Hook, a village close to the town of Goole, in the East Riding of Yorkshire. The property is a listed building that is situated within its own grounds.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was registered with the Care Quality Commission (CQC). 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.

Summary of findings

People told us that they felt safe whilst they were living at Hook Hall. People were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. Staff also told us that they would not hesitate to use the home's whistle blowing procedure if needed.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. Staff had received training on the administration of medication and people told us they were happy with how they received their medicines.

New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people had been employed. On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs.

People told us that staff were caring and that their privacy and dignity was respected. People told us that they received the support they required from staff and that their care plans were reviewed and updated as required.

People's nutritional needs had been assessed and they told us they were very happy with the food provided. We saw that people were encouraged to drink throughout the day.

There was a complaints policy and procedure in place and we saw that any complaints or concerns raised had been dealt with professionally. There were systems in place to seek feedback from people who received a service, and feedback had been analysed to identify any improvements that needed to be made.

The quality audits undertaken by the registered provider were designed to identify any areas that needed to improve in respect of people's care and welfare. Staff told us that, on occasions, incidents that had occurred had been used as a learning opportunity for staff.

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.

Staff had received training on safeguarding adults from abuse and moving and handling. This helped to protect people from the risk of harm.

There were sufficient numbers of staff employed to meet the needs of people who lived at the home. Staff had been recruited following robust policies and procedures.

People were protected against the risks associated with the use and management of medicines. People received their medicines at the times they needed them and in a safe way.

Good

Is the service effective?
The service was effective.

We found the provider understood how to meet the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff undertook training that equipped them with the skills they needed to carry out their roles.

People's nutritional needs were assessed and met, and people told us they were happy with the meals provided by the home.

Good

Is the service caring?
The service was caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive relationships between people and staff on the day of the inspection.

People's individual care needs were understood by staff, and people were encouraged to be as independent as possible.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Good

Is the service responsive?
The service was responsive to people's needs.

People's care plans recorded information about their previous lifestyle and their preferences and wishes for care and support.

Visitors were made welcome at the home and people were encouraged to take part in suitable activities.

People told us that they had no concerns or complaints but they would not hesitate to speak to the registered manager if they had any concerns.

Good

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

Good

Summary of findings

There was a registered manager in post and there was evidence that the home was well managed.

There were sufficient opportunities for people who lived at the home, staff and relatives to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe care and that the premises provided a safe environment for people who lived and worked at the home.

Hook Hall High Street

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.

The inspection took place on 8 December 2015 and was unannounced. The inspection was carried out by one adult social care inspector and an Expert by Experience. An Expert by Experience is someone who has personal experience of using or caring for someone who has used this type of service. The Expert by Experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authority who commissioned a service from the home. We also read the report prepared by Healthwatch following an Enter and View inspection in May 2015; Healthwatch is the independent consumer champion for health and social care in England. The provider was not asked to submit a provider information return (PIR) prior to the inspection. 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.

On the day of the inspection we spoke with five people who lived at the home, one relative, the registered provider, the registered manager, three members of staff, a visiting social care professional and a visiting health care professional. Following the day of the inspection we spoke with another social care professional.

On the day of the inspection we spent time looking at records, which included the care records for four people who lived at the home, the recruitment and training records for one member of staff and other records relating to the management of the service, including staff training and quality monitoring records.

Good

Is the service safe?

Our findings

We asked people if they felt safe living at the home and they confirmed that they did. Two people said, "Yes, of course" and another told us, "It's alright here. I feel safe – well, I have been alright up to now." A relative told us, "I'd give an unequivocal 'yes' to the question of safety. My mother was always falling but now she rarely falls and I put that down to a variety of factors which make up this care home." We asked staff how they kept people safe and comments included, "We use the correct mobility equipment", "We are vigilant and watch people carefully" and "We have had training on safeguarding people."

Training records evidenced that staff had completed training on safeguarding adults from abuse. The staff who we spoke with were able to describe different types of abuse, and they told us that they would report any incidents or concerns to the registered provider or manager. Staff said that they were confident that the registered provider or manager would take appropriate action and ensure issues were dealt with in line with the home's policies and procedures. One member of staff told us, "(The registered manager) is very strict about these things." We saw that any safeguarding incidents were recorded in people's care plans as well as being recorded centrally. This included a record of when the safeguarding team had been contacted to discuss issues and this had not resulted in an alert being submitted. A social care professional told us they had never seen anything of concern when they had visited the home. We noted that the safeguarding procedure and contact numbers for the local safeguarding adult's team were displayed on the home's notice board.

Care plans recorded assessments and risk assessments in respect of moving and handling and the risk of falls. Risk assessments were scored to identify the level of risk involved and recorded the details of any equipment the person required to assist them to mobilise. We observed staff assisting people to mobilise on the day of the inspection and noted that this was done safely; this was also supported by a health care professional who we spoke with. One person had been referred to the falls team as a result of having more than one fall; there was a risk assessment in place for this person to advise staff how to minimise the risk of falls.

There were other assessments in place to assess the risks associated with nutrition, pressure area care, infection prevention and medication. The risk assessments recorded details of the risk, the consequences or harm, the required actions and controls, the actions taken and by whom, and the review date. When people displayed behaviours that could put themselves or others at risk, plans had been developed to advise staff how to manage the person's behaviour to minimise any risk. This showed that identified risks had been considered and that measures had been put in place to try to manage these.

We checked the accident book and noted that accidents and incidents had been recorded appropriately. On occasions we noted that staff had drawn a map to show where in the home the accident had occurred; this helped when accidents were being monitored. We saw that no body maps were used to record where on the body the person had injured themselves; a body map would help staff to monitor the person's recovery. The registered manager told us that they would ensure care workers used body maps in future, as this was part of the home's policy and procedure. We also saw that many accident forms recorded that 'no visible injury' had occurred and we discussed with the registered manager how it was important to seek medical advice, especially when a suspected head injury had occurred. The registered manager told us that medical attention was sought when staff had concerns about a person's well-being and undertook to record this in future.

All medicines were stored in the medication trolley that was fastened to the wall; we noted that external and internal products were stored separately, as recommended. The temperature of the medication fridge and medication cupboard were monitored regularly and recorded; this evidenced that medicines were stored securely and at the correct temperature.

Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The blister packs were colour coded to indicate the time of day the medicines needed to be administered. Staff told us that they colour coded the medication administration record (MAR) charts to correspond with the blister packs; this reduced the risks of errors occurring. Any

medicines that were not stored in the blister pack were stored in the medication trolley; we saw that packaging was dated when opened to ensure the medicine was not used for longer than recommended.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CDs) and there are strict legal controls to govern how they are prescribed, stored and administered. We checked the storage and recording of CD's. We noted that they were stored safely and saw that the stock of medicines held matched the records in the CD book. Two staff had signed the CD book to record when medication had been administered.

Each person's care plan included a list of the current prescribed medication. There was an audit trail to evidence that medication prescribed by the GP was the same as the medication delivered by the pharmacy. There were satisfactory arrangements in place for the disposal of unwanted or unused medication. Staff told us that the registered manager carried out audits of the medication system and that the pharmacist used by the home had also carried out an audit; we did not see these audits on the day of the inspection.

All staff who had responsibility for the administration of medication had completed training. The registered manager told us that they also carried out competency checks on staff to ensure they had the skills they needed to administer medication safely. However, they acknowledged that these were often not recorded as they should be. We checked a sample of medication administration record (MAR) charts and saw that they included a photograph of the person concerned (to aid recognition for new staff) and that there were no gaps in recording. Any handwritten entries on MAR charts had been signed by two people; this reduced the risk of errors occurring. We noted that staff recorded on the MAR chart when medication had been stopped, and that this was also recorded in a separate book and on the staff handover sheet; this ensured that all staff were aware of the person's current medication needs.

We checked the recruitment records for one member of staff. An application form had been completed, references obtained and checks made with the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children or vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children or vulnerable adults. We saw that this information had been received prior to the person commencing work at the home. This meant that only people considered suitable to work with vulnerable people had been employed. Interviews were carried out and staff were provided with job descriptions and terms and conditions of employment. This ensured staff were aware of what was expected of them.

On the day of the inspection we saw there was a senior care worker, two care workers and a domestic assistant on duty, as well as the activities coordinator in the morning. The registered provider also worked as the cook for the home and the registered manager spent time assisting us with this inspection. We checked the staff rotas for a two week period and noted that permanent staff were supported by a small number of agency staff. However, these were 'regular' agency staff who knew people who lived at the home well. One member of staff told us, "There are specific agency staff so they build up a bond with people. We only use agency staff on nights and they are always paired with a permanent member of staff."

Visiting health and social care professionals told us they could always find a member of staff when they needed them. People told us that call bells were answered promptly and we observed that to be the case on the day of the inspection. A relative told us, "I inadvertently knocked the buzzer and before I realised what I had done, someone was there asking if everything was alright." This showed us that there were sufficient numbers of staff to meet the needs of the people who lived at the home.

We saw the registered provider's business continuity plan. The plan identified the arrangements made to access alternative accommodation if the premises needed to be evacuated, and emergency telephone numbers for staff and professionals that might be needed in a time of crisis. The plan advised staff on the action to take in the event of flood, a gas leak, an outbreak of infection and other emergency situations. The contingency plan included personal emergency evacuation plans (PEEPs) for each person who lived at the home. This advised the emergency services about the assistance each person would need if they needed to be evacuated from the building.

There was an updated environmental risk assessment in place for the premises. We saw a list of when the servicing of equipment was due; the list recorded the date of the

Good

Is the service safe?

most recent maintenance certificates. There were current maintenance certificates for the fire alarm system, emergency lighting, the electrical installation, portable appliances, gas installations and the passenger lift. More regular maintenance checks had been carried out in-house; these included window opening restrictors, grab rails, room and water temperatures, call bells, and bath and mobility hoists. Beds with bed rails attached were serviced by the company that supplied the beds.

We noted that the premises were clean throughout and that there were no unpleasant odours.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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, and whether authorisations to deprive a person of their liberty were in good order. We saw that documentation had been completed by the registered manager to apply for DoLS authorisations and that these included the appropriate paperwork in respect of best interest and capacity assessments. The registered manager displayed a good understanding of their role and responsibility regarding MCA and DoLS, and promoting people's human rights.

We saw that there was information available for staff on MCA, DoLS, advanced decisions and Power of Attorney (POA). One person's care plan recorded that a relative had Lasting Power of Attorney. A Power of Attorney is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf.

We saw that care plans evidenced a person's capacity had been assessed and their ability to make decisions considered. Staff explained how they helped people to make day to day decisions, such as showing them a selection of clothes to choose from. One member of staff said, "They still have the right to choose" and another told us, "We present people with options. We also know enough about them to help them make choices – we knew most people when they had the capacity to make decisions."

People who we spoke with did not seem certain whether staff consulted with them and asked for consent before they helped them with care, although we did not observe any concerns about this on the day of the inspection. In care plans, we saw a form that recorded the names of people who had consented to have a flu vaccination; this consent had been obtained before health care staff attended the premises to carry out the vaccinations. At lunchtime we saw that people were asked if they wanted to wear a clothes protector. One person reluctantly agreed then removed the apron; this was accepted by staff who respected their decision.

On the day of the inspection we observed that staff had the skills they needed to carry out their roles, both in respect of care tasks and activities. Staff told us they were happy with the training provided for them. We saw that staff induction training covered the topics of eating, cross infection, pressure area care, communication, personal hygiene, care planning, person-centred care, continence, orientation to the home, the accident procedure and whistle blowing. Staff told us that they shadowed experienced staff as part of their induction training. We saw that staff had also signed a document to record they had a copy of whistle blowing information produced by the registered manager.

The registered manager had defined what they considered to be essential training for staff, including person specific training and service specific training. The topics included were moving and handling / falls awareness, first aid, safeguarding adults from abuse, infection control, care of medicines, food hygiene, health and safety, fire safety, equality, MCA and DoLS, and diversity and the fundamentals of care. The registered manager had also produced numerous information leaflets that had been distributed to staff, such as those for behaviour that challenges, foot care, dignity in care, dementia, hand washing technique, an example care plan, Do Not Attempt Cardiopulmonary resuscitation (DNACPR), and person-centred thinking. Staff confirmed that these leaflets were handed to them and discussed in staff meetings. Although these and more topics had been covered in training sessions both internal and external, it was not clear which staff had attended what training sessions. The registered manager acknowledged that it would be useful to produce a training record that listed all training completed by staff so that their need for refresher training could be more easily monitored.

A social care professional told us that the registered manager was very supportive of learners and that she

encouraged people to undertake qualifications and to progress. We saw that most staff had either achieved a National Vocational Qualification (NVQ) or were working towards the qualification.

There was a staff supervision schedule in place and staff also had annual appraisals. These are meetings when staff have the opportunity to have a one to one meeting with their manager to discuss their performance and any concerns they may have. The registered manager acknowledged that staff supervision and appraisal meetings were behind schedule. However, staff told us that they were very happy with the support they received from the registered manager. They said that the registered manager often worked alongside them and 'led by example'. One care worker told us, "We can always go to (the registered manager) or (the senior) – they are brilliant."

We saw the 'handover' sheets that were used to record any information that needed to be shared with staff. One sheet was produced each day to record any incidents or concerns that the next group of staff on duty needed to be aware of. This information was recorded under room numbers rather than the person's name to retain confidentiality.

People told us they liked the meals at the home and the main meal we saw being served smelt and looked appetising. We saw that staff explained to people what the meal consisted of. One person said, "The food is good – we get joints of meat, you know, just ordinary stuff" and another told us, "For what we pay, I think the food is very good, and I am always satisfied with what I have – I'm highly delighted." There were written menus but these were often adapted to meet people's requests, and the registered provider was aware of each person's likes and dislikes. People told us there was a set meal at lunchtime but they could request an alternative if they did not like the meal on offer and that there were various choices provided at tea time. On the day of the inspection we saw that several different meals were provided at tea time to meet people's individual requests.

We observed the lunchtime experience; there were two dining rooms in use and some people chose to eat in their room. The tables were set with cloths, placemats, cutlery and glasses; one person had a plate guard and this enabled them to eat their meal independently. People were offered clothing protectors. On the day of the inspection a health care professional visited during lunchtime and this delayed staff to some extent. This meant that no drinks were offered until after the meal and that people got served at different times. There was only one member of staff to assist two people with eating their meal and this meant that some people had to wait to be assisted with their meal. This was discussed with the registered manager after the inspection and they told us that meal times were usually more organised to ensure people received one to one assistance, and that they would ensure this was the case in future.

Three people required their drinks to be thickened to prevent them from choking, and we saw that this was how their drinks were served on the day of the inspection. Information from the Speech and Language Therapy (SALT) team was included in people's care plans so that staff had clear information to follow in respect of people's specialised diets. People who had been identified as being at risk of malnutrition or other concerns in respect of their diet were being weighed on a regular basis. In addition to this, some people had food intake charts, and fluid intake and output charts in place. This enabled staff to monitor people's nutritional well-being.

People's records evidenced that a stroke nurse, SALT, the falls team, dieticians and the intensive home care service had been involved in their care. Health and social care professionals told us that there was good communication between themselves and staff. They said that staff asked for advice appropriately and followed that advice. We saw that any contact with care professionals was recorded; this included the reason for the contact and the outcome. In some instances, very detailed reports had been prepared that reflected the advice given by health care professionals. People told us that they could see their GP when they needed to. Staff told us there was a 'named' GP for Hook Hall.

Some people's care plans included information that had been obtained from the Internet about specific illnesses; this helped staff to understand the person's condition and provide appropriate care and support. People had care plans in place in respect of pain if they were not able to communicate this verbally. The plans included signs that staff should be aware of that might indicate they were in pain and needed medication or medical attention.

Good

Is the service effective?

People had patient passports in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff. We saw that patient passports included up to date information.

We saw that, although signage within the premises was minimal, no-one had difficulty in finding their way around the home. Most people required assistance to mobilise around the premises so were helped by staff to locate bathrooms, toilets and bedrooms.

Good

Is the service caring?

Our findings

We observed that staff had a warm and caring approach to people who lived at the home. There was physical closeness between people and staff such as hugs and holding hands, but only when it was apparent that this was something the person welcomed. A visiting health care professional told us, "This is one of the nicest homes I have ever been in. The staff treat the residents like family members" and a social care professional said that staff were pleasant, kind, polite and respectful towards people who lived at the home. They also told us that they had observed that staff genuinely cared about the people they supported and provided person-centred care, commenting, "Staff are relaxed and efficient and do not hurry people."

The registered provider prepared the meals at the home and was in and out of the kitchen throughout the day to chat to people; it was apparent that he knew people well and chatted to them about their lives and their family and friends. One person had recently celebrated their birthday and the registered provider had made them a cake and organised a party.

We saw that care workers moved two people (with their permission) to sit in a different area of the home where they could see the garden through the window and take advantage of the winter sun. They told us they loved to sit and look at the garden. This showed that staff took individual needs and preferences into consideration.

One person was not able to communicate verbally and we saw that they carried a notebook around with them. Staff wrote questions and information in the notebook and the person wrote responses. Along with gestures, eye contact and touch, this enabled the person to communicate with staff who supported them, and to express their views and wishes.

We saw that care plans recorded what people could do for themselves and what activities they required assistance with. One person's general health had improved and this meant they could undertake more tasks for themselves; their care plan had been updated to reflect this. A health care professional told us, "Staff treat people as individuals and respect people's wishes. They encourage people to do things but never make them do things."

On the day of the inspection we saw that staff respected a person's privacy and dignity. Staff explained to us how they achieved this; they said that they made sure doors and curtains were closed and that people were covered up when being assisted with personal care to protect their modesty. Staff said that they explained to people "As they went along" what they were doing, or asked for their permission. They also said, when the GP visited, they asked people if they wanted to see the GP on their own or if they wanted staff to stay with them.

We saw that the policy on confidentiality had been reviewed and records evidenced that this topic was included in staff induction training. The staff who we spoke with understood the importance of confidentiality but also when information needed to be shared to protect people from the risk of harm.

We saw that information about available advocacy services was held at the home. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

We noted that some people had DNACPR notices in place and these had been completed correctly. We saw the copy of an email sent to a GP surgery to inform them that six people's DNACPR forms were due for renewal; this evidenced that the registered manager understood that these forms were only valid until the date recorded on the form. One person's care plan recorded that they had a Living Will in place and the care plan included an explanation of the implications of this in respect of their care at Hook Hall. A living will lets people indicate what type of treatment they want or to refuse some types of medical treatment in certain situations if they lack capacity to make or communicate their decisions at the time.

Good

Is the service responsive?

Our findings

The care plans we saw included care needs assessments, risk assessments and care plans. A pre-admission assessment had been completed prior to the person moving into the home, and this information had been developed into an individual plan of care. Most people who lived at the home had care plans in place for personal hygiene, dressing, nutrition, continence, medication, mobility and falls, social preferences, cognition and sleep. Where necessary, people had more individualised care plans in place for areas such as dysphagia, cerebral vascular accident, catheter care, behaviour, psychological and emotional needs and communication difficulties.

Care workers told us that care plans were developed from information gathered from the person themselves, their family, friends and from health and social care professionals involved in their care. We saw there was a list of these professionals included in each person's care plan.

People had documents in place that recorded details of their life history, including education, work, family relationships, special memories, favourite food and drink, interests, things they did not like and their favourite things. Staff told us that they got to know about people's individual needs and wishes by reading their care plans and by talking to them. It was clear that care workers knew people's individual personalities and care needs. Health and social care professionals told us that staff were always able to answer their queries because they knew people well.

We checked the care plans for four people who lived at the home and saw that they were reviewed and updated in-house each month. In addition to this, more formal reviews were completed periodically by the local authority to check that the person's needs continued to be met by the home. This meant that care plans were up to date and a true reflection of the person's current care needs.

One person told us that staff sometimes assisted them to get up in a morning before they were properly awake. The registered manager told us that staff needed to remind some people that it was time to get up for breakfast, otherwise they would sleep too long and their meal times would be disrupted. She said that other people chose to get up very early and they were assisted to do so by staff.

On the day of the inspection we saw that some people were having breakfast after everyone else as they had chosen to have a 'lie in'. This indicated that people could get up and dressed at a time chosen by them.

Visitors told us they were always made welcome at the home. A relative told us, "They are always polite and helpful on the phone and they know immediately who I am and who I am ringing about. When I visit they are always welcoming and they let me know if there is any change in the situation."

The activities coordinator worked on four mornings and three afternoons a week, and another activities coordinator worked on two afternoons a week. On the day of the inspection we saw that they encouraged people to take part in group activities, such as jigsaws and games. They told us they tended to play a ball or balloon game before morning coffee, and crafts after morning coffee. We noted that there was calming music playing whilst activities were being undertaken. We saw that the activities coordinator also went to see people who stayed in their own room to support them with activities, such as sewing. They were skilled in engaging people in conversation or activities and these interactions clearly enhanced people's quality of life. A relative told us that the input from the activities coordinator had provided stimulus and conversation for their family member.

A volunteer visited the home one afternoon a week to support people to play dominoes. The volunteer was the spouse of someone who had previously lived at the home; they told us they had been so happy with the care their spouse had received, they had chosen to return to the home each week to help organise activities. One person who lived at the home regularly went out for a walk and one person was taken out by the registered provider; this (along with communication with visitors and staff) enabled people to keep in touch with the local community.

The activities coordinator also produced a newsletter that informed people who lived at the home and relatives / friends about what activities and events were taking place. A copy was available in the entrance hall for any visitors to the home to take away. We saw that the newsletter recorded staff news (for example, new and returning staff), activities that had been carried out (including photographs) and details of forthcoming church services.

Good

Is the service responsive?

We saw that the complaints procedure was displayed in the home. We checked the complaints log and saw that the only complaints received had been two recent complaints received by the CQC which we had asked the registered manager to investigate. These had been recorded thoroughly.

People who we spoke with on the day of the inspection told us they would speak to staff if they had any concerns. One person said, "If I had any worries I would just talk to the staff and they would understand and help me." Staff told us they would deal with any minor complaints if they could, but they would inform the registered manager about any more serious concerns. They said they were confident that the registered provider and / or registered manager would deal with any concerns or complaints professionally and thoroughly. Staff told us they would always record any concerns or complaints shared with them. We saw the "Areas of concern" book where any concerns received had been recorded and saw there was a record of how these had been dealt with.

A visitor told us, "I don't really know how to go about making a complaint, but if I had any concerns I would speak to the provider or manager."

Formal 'resident' meetings were no longer taking place. Instead, the activities coordinator spent time with people to check they were happy with the care and support provided for them. Any concerns raised would be shared with the registered provider and / or manager and recorded.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection and they had been registered with the Care Quality Commission for a number of years; this meant the registered provider was meeting the conditions of their registration. This also led to the home providing a consistent service.

We asked for a variety of records and documents during our inspection. We found that, although these were available, they were not always easily accessible, although they were stored securely. Information was often recorded in too many places and needed to be rationalised; this was acknowledged by the registered manager. A number of policies and procedures had been updated in February and March 2015; these included confidentiality, consent to care and treatment, privacy and dignity, data protection, DNACPR, fire safety, nutrition, moving and handling, service user views, and physical intervention and restraint.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

We saw that there were clear lines of communication between the registered manager and staff. The registered manager knew what going on within the service and about the specific needs of people living there. We asked staff about how well the home was managed. They were very positive and comments included, "Lovely people", "Very fair", "They bend over backwards to try to accommodate staff", "(The manager) has standards – she is very fair and won't accept anything other than the best" and "Firm but fair." A relative said, "The owner and his partner (the registered manager) are here 24 hours a day and they could not be kinder or more supportive. I want to endorse just how good they are."

There were no written values displayed in the home but the aims and objectives were recorded. One of these was "To provide a safe, caring, comfortable and homely environment." We asked the registered manager about the culture of the service and she said, "This is my home and I hope people who live here think it is theirs." Staff spoke positively about the culture of the service. Comments included, "Homely – home from home", ""Feels like a family", "Close but professional" and "Happy and pleasant." A health care professional told us, "Staff would 'go the distance' before giving notice – they try everything they can to meet a service user's needs."

A relative told us that they had not been involved in relative meetings as they lived away, but they believed there were coffee mornings when relatives came into the home and chatted to the registered provider, registered manager and staff on an informal basis. We saw numerous thank you cards in quality assurance records that had been sent to the home by relatives and friends of people who lived at the home or had previously lived at the home.

The most recent staff meeting had been in October 2015. We saw that the topics discussed included key working, training, infection control, personal hygiene and housekeeping. Handouts had been given to staff on the whistle blowing policy and the Human Rights Act. In addition to this, staff had been informed about a complaint / safeguarding information that had been received by CQC which the provider had been asked to investigate. This evidenced that the registered manager was open and transparent about incidents that had occurred at the home. At the previous staff meeting we noted that staff had been given a handout on hoist safety. Each member of staff had an information pack and minutes of staff meetings were place in the pack for them to read. Staff confirmed they attended meetings and that these meetings were a 'two way process'. They said they were invited to ask questions, raise concerns and make suggestions. Staff told us that any issues or concerns would be discussed openly. They said they would "Bounce ideas off each other" to analyse how things had gone wrong and how they could be prevented from occurring again.

A variety of audits had been carried out, including audits on fire safety, risk assessments, laundry services and kitchen cleanliness and safety. Staff told us that the registered manager undertook audits on the medication systems and that the pharmacist used by the home also carried out medication audits; we did not see these on the day of the inspection. The aim of the quality monitoring system was to identify any patterns or areas requiring

Good

Is the service well-led?

improvement, and we concluded that the home had effective systems for monitoring the quality of care and support provided, and for driving improvements within the service.

Healthwatch carried out an Enter and View inspection in May 2015. The report they produced recorded they had received positive feedback from people who lived at the home and relatives, and had observed that the environment, care plans, activities and meals were provided that met people's needs.

Satisfaction questionnaires had been distributed to people who lived at the home in July 2014. The collated responses had been analysed and an action plan had been produced. The action plan recorded that six people said they were not aware of the complaints procedure. As a result, the complaints procedure was displayed again in the home and everyone's family representative was also sent a copy. A survey had been distributed to people who lived at the home in December 2015 and the responses had not yet been received or collated. A relative survey had also been sent out in December 2015; again, the responses had not yet been received or collated. The registered manager told us that any issues or concerns identified through these surveys would be discussed with people who lived at the home, staff and relatives so that their opinions could be used to make any improvements needed.

We asked if there were any incentives for staff. We were told that staff received an increase in pay when they achieved a NVQ award. In addition to this, they supported staff to access additional training; two staff were undertaking a management qualification and moving and handling 'train the trainer' was being sourced for another member of staff. This evidenced that the registered provider and manager encouraged staff to gain qualifications and to view care work as a career.