St Ives Lodge Care Ltd

St Ives Lodge Residential Care Home

Inspection report

25-29 The Drive
Chingford
London
E4 7AJ

Tel: 02085297952
Website: www.stiveslodgecarehome.co.uk

Date of inspection visit:
20 November 2017
21 November 2017

Date of publication:
18 December 2017

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 20 and 21 November 2017 and was unannounced. At the previous inspection in November 2015 the service was overall rated as Good.

St Ives Lodge Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St Ives Lodge Residential Care Home accommodates 35 people in one adapted building. At the time of our inspection 31 people were living at the home. People were accommodated over three units. One unit specialises in providing care to people with dementia, and the two other units are a mixture of residential care and dementia care.

There was a registered manager at this service. 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's needs were assessed and their preferences identified as much as possible across all aspects of their care. Risks were identified and plans were in place to monitor and reduce risks. People had access to relevant health professionals when they needed them. There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed. Medicines were stored and administered safely. The home environment was clean and the home was free of malodour.

Staff undertook training and received regular supervision to help support them to provide effective care. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is legislation protecting people who are unable to make decisions for themselves or whom the state has decided need to be deprived of their liberty in their own best interests. We saw people were able to choose what they ate and drank. People told us they enjoyed the food. The home was well decorated and adapted to meet their needs of the people

People and their relatives told us that they were well treated and the staff were caring. We found that care plans were in place which included information about how to meet a person's individual and assessed needs. People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service. People had access to a wide variety of activities.

The service had a complaints procedure in place and we found that complaints were investigated and

where possible resolved to the satisfaction of the complainant.

Staff told us the service had an open and inclusive atmosphere and the registered manager was approachable and open. The service had various quality assurance and monitoring mechanisms in place. These included surveys, audits and staff and resident meetings.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

St Ives Lodge Residential 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.

Before we visited the home we checked the information that we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placements at the home, the local borough safeguarding team, the clinical commissioning group pharmacist, the speech and language therapist and the GP surgery that provides services to the home.

This inspection took place on 20 and 21 November 2017 and was unannounced. The inspection team consisted of two inspectors, a nursing dementia specialist and an expert by experience, who had experience with older people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection we observed how the staff interacted with people who used the service and also looked at people's bedrooms and bathrooms with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with six people who lived at the home and four relatives during the inspection. We spoke with the providers, the registered manager, the deputy manager, one senior care worker, two team leaders, two care workers, the chef, one kitchen assistant, and the activities co-ordinator. We also spoke with a district nurse and a Parkinson's disease nurse specialist who visited the home. We looked at 10 care files, staff duty rosters, five staff files which included recruitment and supervision records, a range of audits, minutes for various meetings, medicines records, accidents and

incidents, training information, safeguarding information, a health and safety folder, and policies and procedures for the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt the service was safe. One person told us, "Oh yes, I do [feel safe]." Another person said, "I buzzed a buzzer in the middle of the night once because I needed the toilet and they came straight away."

The home had up to date safeguarding and whistleblowing policies that gave guidance to staff on how to identify and report concerns they might have about people's safety. The safeguarding policy was available to people and staff on noticeboards throughout the home. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns. Staff said they felt they were able to raise any concerns and would be provided with support from the registered manager. The deputy manager told us, "I would take seriously. I would start the investigation straight away. I have to inform the safeguarding team and CQC." One staff member said, "I'd report any safeguarding issues to the [registered manager] but if I was not happy with the response I would whistle blow."

The registered manager told us and we saw records that showed there had been four safeguarding incidents since the last inspection. The registered manager was able to describe the actions they had taken when the incident had occurred which included reporting to the Care Quality Commission (CQC) and the local authority. This meant that the service reported safeguarding concerns appropriately so that CQC was able to monitor safeguarding issues effectively.

Care files each contained a set of risk assessments, which were up to date, detailed and reviewed regularly. These assessments identified the risks that people faced and the support they needed to prevent or appropriately manage these risks. Risk assessments included nutrition, fire safety, manual handling, mental health, falls and moving and handling. For example, one person had been assessed at risk of falls. The risk assessment gave staff guidance on how to minimise the risks for this person. Records showed people and their relatives had consented to and participated in these risk assessments wherever possible.

The premises and equipment were managed in a way intended to keep people safe. Regular checks were carried out on hoists, emergency lights, bedrails, alarm systems, windows, water quality and temperature, and fire equipment. Records showed that fire safety checks and drills were done regularly .The service had an in-house maintenance person and a system in place to report and deal with any maintenance issues. One staff member told us, "We have a standing hoist and a full body hoist. They've been checked and they put a date when they were checked." The same staff member said, "If something not working you need to report. Usually dealt with quick."

There were sufficient staff on duty to provide care and support to people to meet their needs. The registered manager told us staffing levels were based on people's needs. Call bells were answered promptly and care staff were not hurried in their duties. The registered manager and staff told us staffing numbers had increased during the day and night to meet people's increasing needs. Records confirmed this. The deputy manager said, "We increased staff a few months ago. In the past it was a struggle but now a good ratio with the additional staff." One staff member told us, "There are enough staff. As soon as someone requires

assistance we will be there." One relative told us, "Yes I'm happy with the staff ratios. I've never seen anything here to cause me concern." Another relative said, "There is always plenty of staff. I've been to other care homes before and they're not anything as good as this."

During the inspection we checked medicines storage, medicines administration record (MAR) charts, and medicine supplies. All prescribed medicines were available at the service and were stored securely in locked medicine cupboards within a locked treatment room. This assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people using the service.

Current fridge temperatures were taken each day (including minimum and maximum temperatures). Records confirmed the fridge temperature was in the appropriate range. This meant that medicines requiring refrigeration were stored at appropriate temperatures.

People received their medicines as prescribed. There were no gaps in the records of medicines administered, which provided a level of assurance that people who used the service were receiving their medicines safely, consistently and as prescribed. Medicines were administered by staff that had been trained in medicines administration. The GP for the home told us, "The medications are given appropriately, requested appropriately and in a timely manner." A Parkinson's disease nurse specialist said, "[Staff] very aware of timing of medication which is crucial."

People received controlled drugs as prescribed. Controlled drugs are medicines which are legally subject to special storage and recording arrangements. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities done by two members of staff. Records confirmed this. Medicines to be disposed were placed in appropriate waste bins and there were suitable arrangements in place for their collection by a contractor.

Observations showed people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. Records showed people had PRN protocols that had been completed with input from the GP.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of medicines audits completed by the home, the local pharmacy and the clinical commissioning group (CCG).

Accident and incident policies were in place. Accidents and incidents were documented. Records showed that incidents were responded to and outcomes and actions taken were recorded.

The home environment was clean and the home was free of malodour. Records showed staff had completed training on infection control. Staff had access to policies on infection control which covered such topics as clinical waste, disposable protective clothing and expectations of infection control training for staff. Records showed infection control had been recently discussed in the staff meeting for October 2017. The Food Standards Agency had recently awarded the home's kitchen a rating of 'five' which meant the kitchen was found to have 'very good' hygiene standards. The registered manager told us and showed us records of a regular infection control audit that covered spot checks and clinical waste observations. Observations during the inspection showed staff wearing personal protective clothing for tasks such as preparing food, personal care, serving food and cleaning. One staff member told us, "We use gloves and an apron. We change the gloves with every person." Another staff member said, "We need to wash our hands to stop the spread of infections. Every task I wash my hands. We had training on infection control." One

relative told us, "There's no smell."

Good

Is the service effective?

Our findings

People who used the service and their relatives told us they were supported by staff who had the skills to meet their needs. One person said, "The staff are very good and helpful." One relative told us, "The staff are very good." Another relative said, "All the staff here are wonderful."

Appropriate referrals to external services were made to make sure people's needs were met. Records showed people's needs were assessed in order to identify their support needs regarding nutrition. Details of people's dietary needs, food preferences and likes/dislikes were recorded in people's care files. Daily food and fluid intake was monitored for people who were at risk of malnutrition. Records showed people's weight was monitored monthly. If there were significant changes they would advise the GP and referrals were made to a dietician and the speech and language therapist (SALT). The SALT person for the home told us, "Referrals are received and advice acted upon."

The home applied their learning effectively and in line with best practice. For example, the home had started using the PEACE plan. The PEACE plan (Proactive Elderly Persons Advisory Care plan) is a document to help guide health care professionals in delivering the best care to frail, older people with life-limiting illnesses (such as those with Parkinson's', advanced dementia and cancer) who are anticipated to be in the last year of their life and reside in a care home. It records discussions between the older person and/or their representatives and the geriatric team about what that best care might look like in the future when the older person's health starts to decline further. Discussions may cover topics such as feeding, dealing with infections and whether going to hospital might be a beneficial or detrimental event for the older person. The SALT person for the home told us, "It is great to see that [registered manager] is helping to implement PEACE plans. I only wish other care homes did the same."

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. The assessment looked at the person's medical history, mental capacity, mobility, medicines, nutrition, likes and dislikes, religious and cultural needs and hobbies.

People's cultural and religious needs were respected when planning and delivering care. Records showed people had access to spiritual activities of their choice. One staff member told us, "We have residents from different religions. We have to respect their rights." Another staff member said, "I will always adjust my schedule to make sure they can pray at the right time." During our inspection we saw people from different religious organisations visit people in the home. One relative told us, "They [staff] take [relative] to [place of worship] once a month."

Our observations showed that staff asked people about their individual choices and were responsive to that choice. For example, one staff member was overheard asking a person, "Do you want to sit in the chair [person]?" Throughout the inspection we overheard people being asked what they would like to do, different drinks being offered and food choices. One staff member told us, "[People who used the service] have a choice. We ask what clothes they want to wear and what meal." One person told us, "Yeah, you get choices."

Staff we spoke with told us they received regular training to support them to do their job. Records confirmed this. One staff member told us, "I have always been impressed with the training here." Another staff member said, "I found the training in dementia excellent." They also stated, "The training I have attended helped me understand how people with dementia might feel and what I could do to make things better for them." Records showed the training included health and safety, manual handling, safeguarding adults, person centred care, infection control, food hygiene, pressure care, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), challenging behaviour, fire safety, basic first aid and dementia. The staff files showed that all of the staff had completed the induction programme, which showed they had received training and support before starting work in the home.

There was an effective supervision and appraisal system in place. Staff spoken with told us they were provided with one to one and group supervisions with their senior and the registered manager. The supervision sessions enabled staff to discuss their training and development needs. We saw records of supervision during the inspection and noted areas such as people's safety and wellbeing were regularly discussed. Staff were supervised every six to eight weeks. We noted the registered manager arranged group supervision for staff when required. Areas discussed were more general than in individual supervision and reflected topics such as handover of shifts, cleaning schedules, training needs and promoting people's dignity. One staff member told us, "Overall I think we discuss everything we need to in order to make this home the best." Another staff member said, "We talk about everything. It helps me as we talk about what we are doing ok and where we need to improve."

People told us they liked the food. One person told us, "The food is very nice. They got a good chef." Another person said, "I'm quite happy with it. They [staff] come round to tell what it is and you choose." A relative told us, "There's a good variety with the choice of food, which looks very good and well-presented and appetising." Another relative said, "The food is fresh and lovely."

The chef was aware of the people who were on specialised diets and explained the meal preferences for these people which were reflected in the care plans we looked at. The chef told us that people could ask for alternatives to the food choices for that day and people confirmed this. There was a rolling 12 week food menu in place which included at least two hot meal options plus dessert. People could request a culturally specific meal and we saw that one person had a separate food menu that was specific to their country of origin. On the first day of the inspection the main meal on offer was chicken and asparagus fricassee with vegetables or toad in the hole. The dessert available was jam roly poly with custard. Staff told us and records confirmed people were asked their food option on the previous day. The food for people who were at risk of choking was presented well and all blended separately allowing people to experience and taste the different flavours.

During the lunch time period we saw people being offered a range of drinks including white and red wine. Meals were attractively presented and there was a relaxed and calm atmosphere. Staff members chatted with people while they waited for their food to be served. Once all the food was served we observed the staff members sit with the people who used the service and eat their meal together. People who required assistance with eating were not rushed and staff talked to them in a gentle and encouraging way. People could choose where they wanted to have their meal. One person told us, "You can get your meals in your room."

People were supported to maintain good health and to access healthcare services when required. Records showed people received visits from a range of healthcare professionals such as GPs, district nurses, podiatrists, dentists, chiropodists, opticians and dieticians. One relative told us, "They take [relative] to the eye clinic as part of monitoring her diabetes and we use the home's GP." On the day of our inspection we

observed a district nurse and Parkinson's nurse specialist visiting people. The Parkinson's disease nurse specialist said, "[Referrals] straight away to me and the GP." The district nurse said, "If I suggest something, it is done." This showed the service was seeking to meet people's health care needs.

The home was well decorated and adapted to meet their needs of the people. Since our last inspection the provider had invested in the property. During our inspection we saw decorators were updating the home. The provider had built a new building to house their training and activities resources. The outside grounds were well kept and spacious for people. Handrails were available outside to support people. Specialised equipment was available for people such as hoists, specialised baths and walking aids.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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 any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager knew how to make an application for consideration to deprive a person of their liberty. We saw applications were documented which included detailing risks, needs of the person, and ways care had been offered and least restrictive options explored. Where people had been assessed as not having mental capacity to make decisions, the registered manager was able to explain the process he would follow in ensuring best interest meetings were held involving relatives and other health and social care professionals. The service informed the Care Quality Commission (CQC) of the outcome of the applications. We saw evidence of these principles being applied during our inspection.

Staff were seen supporting people to make decisions and asking for their consent throughout the inspection. People told us that staff members asked their consent before helping them. This consent was recorded in people's care files. One staff member said, "We ask everything. I knock on the door and ask to come in. I will say I am here to give personal care. People with dementia you still have to ask them." One relative told us, "They [staff] will always tell [relative] what they are going to do before they do it." This meant the service was meeting the requirements relating to consent, MCA and DoLS.

Good

Is the service caring?

Our findings

People and their relatives told us that they were well treated and the staff were caring. One person told us, "They [staff] talk to me properly and they're polite." Another person said, "They [staff] are kind and caring and if I'm not here [lounge area], they come to look for me." One relative told us, "They [staff] care without fail. In the attitudes, approaches, the handling of people, the rapport with them. It's person-centred."

Staff knew the people they were caring for and supporting. Staff we spoke with were able to tell us about people's life histories, their interests and their preferences. One staff member told us, "They like us. I am always friendly with them." Another staff member said, "Sometimes I feel sad when they die as I spend a lot of time with them." The Parkinson's disease nurse specialist said, "They [staff] are caring. It is consistent. They know the people here. It's a calm environment." The SALT person for the home told us, "The staff are caring towards [people who used the service]."

Staff communication with all residents was warm and friendly, and staff showed compassion when talking about people who lived at the home. Throughout the day we saw staff sitting with people holding their hand and rubbing their backs whilst speaking to them. Staff delivered care in a manner that was flexible and attentive to people's individual needs. The district nurse said, "I can see communication between the staff and [people who used the service] is very good." One person told us, "It's nice and quiet and the people are friendly. You can do your own thing"

People and their relatives were actively involved in making decisions about the care and support provided. Care plans were reviewed regularly with input from people and their relatives. Records confirmed this. One relative told us, "I was involved in [relative's] reassessment with [staff member] and signed the paperwork." Another relative said, "I was involved in the care plan and recently did an update. I signed for it."

People's privacy and dignity was respected. Staff told us they knocked on people's doors before entering their rooms and we saw this during the inspection. Staff we spoke with gave examples how they respect people's privacy. For example, people who wanted to pray in their room were left alone to do so. One relative said, "The staff are very friendly and respectful and approachable."

People's independence was encouraged. Staff gave examples how they involved people with domestic tasks and doing certain aspects of their personal care to help become more independent. This was reflected in the care plans for people. One staff member told us, "We try to get them to do as much as they can." Another staff member said, "We have [person who used the service] who wants to wash herself but was have to help her wash her back."

People were supported to maintain relationships with their family and friends. Details of important people in each individual's life were kept in their care plan file. Relatives and friends were welcomed to the service and there were no restrictions on times or length of visits. During the inspection we saw family and friends welcomed to the service.

We looked at people's bedrooms with their permission. The rooms were personalised with personal possessions and were decorated to their personal taste, for example with family photographs and soft toys. One person told us, "I love my room." One relative said, "[Relative's] bedroom is personalised."

Good

Is the service responsive?

Our findings

People told us they enjoyed living at the home and the care they received was responsive to their needs. One person said, "They [staff] listen." A relative told us, "They [staff] are very responsive."

Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's needs. They included guidance for communication, mobility, mental health and capacity, medicines, personal hygiene and skin care, dressing, eating and drinking, cultural and religious needs, toileting, family involvement, night care and sleep pattern, moving and handling, and leisure and social care. Care plans were written in a way that reflected people's individual preferences. For example, one care plan stated for a person's night care needs, "[Person] likes to go to bed at 7.00pm on the dot." Another care plan stated, "[Person] likes to wash and dress himself. [Person] likes a cup of tea at 9.30am."

The care files had a section called 'my life before you knew me' which included the person's family history, working life and things they like to do. Records showed care plans had been reviewed regularly or as the person's needs changed. The plans had been updated to reflect these changes to ensure continuity of their care and support. Detailed care plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

People had access to planned activities. The home employed an activities co-ordinator who worked Monday to Friday. The activities co-ordinator told us the care staff provided activities on weekends and support during the week. Activities for people were individualised. For example, the home had a men's and women's club which provided activities specific to that gender. The men's club did activities such as playing dominos and visiting the local pub for lunch. The women's club did activities such as crochet and knitting. Group activities were available for everyone such as games and arts and crafts. The activities co-ordinator told us they had a monthly budget which provided for external activities such as music therapy, entertainers, pet therapy and exercises. People and relatives told us they enjoyed the activities. One person said about the activities, "[We] play games, cinema this afternoon, music and the singers. We play Monopoly and we go out to a pub once a week for a meal. There's a lot of activity going on." Another person told us, "I like the activities and the outings." A third person said, "I get a taxi for outings. Sometimes I go out for a meal. There's singing and dancing. We went to see a couple ballroom dancing. It was beautiful." A relative said, "They do outings like the boat trip on the river. They go to tea dances. Pub lunches and they're going to a Christmas market. They have people coming in to do singing." Another relative told us, "The social side of it is very good. There's constant stimulation."

During our inspection we saw people involved with activities. On the first morning of the inspection we saw staff sitting with people playing board games and doing quizzes. In the afternoon an external company provided a cinema experience for people which included watching a film on a large screen with popcorn and sweets. We saw the activities co-ordinator made particular effort to include all the people who had advanced dementia through conversation and as she knew them well she was able to talk to them about subjects and in a manner which engaged them. The activities co-ordinator told us she provided one to one

activities for people in their room. Records confirmed this. One relative told us, "The staff are sociable with [relative] in her own room."

There was a complaints process available and this was on display in the communal areas so people and their relatives were aware of it. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints policy and we saw there was a clear procedure for staff to follow should a concern be raised.

Most people and relatives knew how to make a complaint and knew that their concerns would be taken seriously and dealt with quickly. There were systems to record the details of complaints, the investigations completed, actions taken as a result and the response to the complainant. Records showed there had been six formal complaints during the last 12 months. We found the complaints were investigated appropriately and the service aimed to provide resolutions in a timely manner. One person said, "I'd tell whoever is in charge." A relative told us, "If there was a problem with [relative's] service I'd talk to [deputy manager] and then [registered manager] and if not resolved then CQC." Another relative said, "I'd make them [complaints] to the management."

Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "We would ask them what their needs are, a preference to social events and the gender of carer." Another staff member told us, "Everyone is equal. We have a policy on equalities. Would do a life history and talk through things." Training records showed staff had completed equality and diversity training. The home had a policy on equality available to staff. The home also had available external policies for staff on supporting people who identified as LGBT in a social care environment and a toolkit to help people 'stay out of the closet.' People who identify as LGBT quite often hide their sexual orientation when living in supported accommodation to avoid the risk of possible discrimination.

At the time of our inspection the home did not have any people receiving end of life care. Records showed staff had received training in end of life care. The registered manager told us the home worked with palliative care teams and the GP when people were at end of life. The service had an end of life policy called "End of Life Care" which was appropriate for people who used the service. The registered manager said, "We will never let someone die alone. Will put on an extra member of staff on. I want people to die with dignity." One staff member said, "We involve the GP and families. We come up with an end of life care plan. We try and make residents as comfortable as possible." The GP for the home told us, "We have found that end of life care is well organised, caring and the [people] and relatives are treated with the utmost dignity and respect." We saw cards of thanks and appreciation from relatives in relation to the end of life care provided to people who had lived in the home. The cards showed how staff had supported people with kindness and empathy. Some comments included, "We felt so happy for [relative] that he did not end his life in loneliness at [hospital] but with people who knew him and loved him. He slowly ended his life in dignity with carers who had given him so much support", and "I cannot put into words how much I appreciate all your hard work that you put into [relative's] final minutes. She looked so comfortable."

Good

Is the service well-led?

Our findings

People and their relatives told us they thought the service was well managed and they spoke positively about the registered manager. One person said, "She's [registered manager] very good." Another person told us, "She's very nice. She's firm and understanding." A relative said, "I think she's excellent. She works very hard. She's available and approachable and listens." Another relative told us, "[Registered manager] is very friendly. She makes you feel as though she runs the place as she would for her own family." A third relative said, "She is wonderful. The staff love her and she gets things done."

Staff told us they liked the registered manager. They said they felt comfortable raising concerns with them and found them to be responsive in dealing with any concerns raised. One staff member told us, "The manager is very approachable." Another staff member said, "She's a good manager. She cares for the residents and staff. Any problems you can go to her." A third member of staff told us, "She is brilliant. I've learnt a lot from her. If you go to her for something she will always have time to answer you."

The provider had a number of quality monitoring systems in place. These were used to continually review and improve the service. The registered manager told us they conducted a monthly medicines audit, infection control audit, health and safety audit, unannounced night checks, and staff observations. The registered manager also did a quarterly audit which looked health and safety, accidents and incidents, risk assessments, infection control, and first aid. Records confirmed this.

Six monthly surveys were undertaken annually for people who used the service and relatives. The last survey for people using the service was conducted in February 2017. The survey covered environment of the home, care and treatment, care planning, activities, medicines, meals and nutrition, staff, complaints and any other concerns. Overall the results were positive. Feedback comments on the survey included, "I was made to feel comfortable discussing anything with you and the staff quite soon after [relative] moved in and this greatly eased the transition", "They always offer a cup of tea even when busy" and "Whenever I have had any suggestions regarding my [relative] I have found [registered manager], [deputy manager] and staff generally to be approachable and eager to help".

The home held regular staff meetings where staff could receive up to date information and share feedback and ideas. Meetings were also held for senior and night staff. Topics included in staff meetings were audits, medicines, documentation, infection control, duty of candour, safeguarding, health and safety, care plans and risk assessments, communication, teamwork and having compassion towards people who used the service. One staff member told us, "Every month we talk about everything, what we need, and resident's needs."

Residents meetings were held every three months to provide and seek feedback on the service. Topics recorded for the meetings included food menu, hygiene, health and safety, staffing, safeguarding, laundry, activities and cultural needs. One person said, "[Staff] talk about different things. They listen and change things."

The home provided quarterly reports to the local authority that had placements in the service. Records showed these reports looked at the action plan updates from the last (local authority) monitoring visit, staffing, supervision, recruitment, training, policies and procedures, quality assurance, safeguarding, and home environment. The local authority confirmed they received the quarterly reports and regular contact and updates were maintained.

The home worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the home had joined NAPA (National Activity Provider's Association). NAPA provides training and support for meaningful activities for older people. The registered manager told us she attended the local authority forum and the National Care Association (NCA) meetings with other health and social care providers to share and gather information. The registered manager told us the next 12 months will focus on more dementia activities for people who used the service. For example, the registered manager had sourced an aromatherapy vapour machine designed specifically to stimulate the senses of people diagnosed with dementia. Also the registered manager was in the process of having a textile wall placed in the dementia unit to stimulate people.