Parkfield Health Care Limited

Westfield Manor

Inspection report

43 Westfield Lane
Idle
Bradford
West Yorkshire
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Tel: 01274610442

Date of inspection visit:
01 February 2017

Date of publication:
24 February 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

Westfield Manor provides accommodation and nursing care to a maximum of 25 people living with dementia and/or mental health needs. The home is located in quiet location close to the church in the Idle area of Bradford. All the accommodation is in single rooms and there are two small communal lounges and a dining room where people are able to spend time. The home was registered in October 2016 and has not been subject to any previous inspections whilst managed by the current care provider.

The inspection took place on 1 February 2017 and was unannounced.

A registered manager was in place. '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 and relatives all spoke positively about the service. They said that people were safe living in the home and that staff were kind, friendly and treated people well. They told us that the registered manager and owner were friendly and approachable and that they had significantly improved the home since they had taken over ownership and management of it.

Safeguarding procedures were in place and staff had a good understanding of how to identify and act on any allegations of abuse. Incidents were logged, investigated and action taken to keep people safe. Risks to people's health and safety were assessed and clear plans of care put in place to help keep people safe.

The premises was safely managed. Recent improvements had been made to the environment to make it more pleasant and homely. Further refurbishment work was planned throughout the building.

There were enough staff available to ensure people received prompt and attentive care. Staff had time to chat with people as well as meeting their care and support needs. Recruitment procedures were safe to help ensure staff were of suitable character to work with vulnerable people.

People and relatives told us staff were competent and well trained. Staff had been provided with a range of training relevant to their role and the registered manager had installed a culture where staff sought out new knowledge and disseminated to their peers.

People and relatives spoke positively about the food provided by the home. There was sufficient choice and people received appropriate support where required.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation if Liberty Safeguards (DoLS).

People's healthcare needs were assessed and the service worked with local health professionals to meet those needs.

Staff treated people fairly and with dignity and respect. Staff knew people well and good positive relationships had developed between people and staff. People's diverse needs were taken into account and reasonable adjustments were made to the way the service was delivered to meet those individual needs.

Care plan documentation was well organised, demonstrated people's needs had been fully assessed and showed that care and support interventions were carried out in line with people's plans of care.

People and relatives told us they were involved in people's care and support and felt listened to.

People and relatives said they were highly satisfied with the service and felt able to talk to the registered manager about any concerns or complaints.

People, relatives and staff all said the registered manager and owners were very approachable, understanding and effective in leading the home. They all said significant improvements to the culture, documentation and care outcomes had been achieved as a result of their leadership. We found the service to be well organised with the service committed to continuous improvement.

Audits and checks were undertaken and these were used to further improve the service. People's views and feedback was used to make positive changes to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People and relatives told us that people were safe living in the home and they were encouraged to raise any concerns. Safeguarding procedures were in place which were well understood by staff.

Risk assessments were in place and were subject to regular review. Action was taken to investigate incidents to help prevent a re-accordance.

There were enough staff available to ensure people received prompt and attentive care. Robust recruitment procedures were in place to ensure staff were suitable to work with vulnerable people.

The premises was safely managed and a programme of refurbishment was underway to further improve the environment.

Is the service effective?

Good

The service was effective.

Staff received a range of training relevant to their role and had all been appointed 'Champions' in specific subjects to further develop the expertise of the team.

The service was acting within the legal framework of the Mental Capacity Act and Deprivation of Liberty Safeguards. Best interest processes had been followed where people lacked capacity.

People spoke positively about the food and we saw people had access to suitable choice of meals. Mealtimes were a pleasant and relaxed experience.

People's healthcare needs were assessed and the service worked with a team of health professionals to meet people's individual needs.

Is the service caring?

Good

The service was caring.

Staff treated people with a high level of dignity and respect. People all spoke positively about staff and said they were kind and friendly.

Staff had developed positive relationships with people and knew them well.

People and relatives were listened to and their thoughts and feelings used to make positive changes to care and support arrangements.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and detailed and person centred plans of care put in place for staff to follow. People and relatives said people's needs were met by the service.

People had access to a range of activities with further improvements planned through the recruitment of a permanent activities co-ordinator.

People and relatives were very happy with the service and said they had no cause to complain. They said they felt able to raise issues and complaints and the registered manager was very approachable.

Is the service well-led?

Good

The service was well led.

People, relatives and staff all spoke positively about the registered manager and provider and said they were dedicated, approachable and had delivered significant improvement to the service.

We found a positive and inclusive culture within the home. The home was well organised and focused on continuous improvement of the service.

A range of audits and checks were undertaken which were used to make further improvements within the home.

People's feedback was used to improve their care experiences.

Care Quality Commission

Westfield Manor

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 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 1 February 2017 and was unannounced. The inspection team consisted of an adult social care inspector and a specialist advisor nurse who specialised in mental health and the Mental Capacity Act (MCA).

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with four people who used the service, five relatives, three care workers, a member of the cleaning staff, the cook and the registered manager who was also working as the nurse on duty.

We looked at elements of five people's care records and other records which related to the management of the service such as training records and policies and procedures. We observed care and support and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting the local authority safeguarding and commissioning team. We also spoke with a health professional who regularly liaises with the service.

Good

Is the service safe?

Our findings

People told us they felt safe and supported by staff. Their comments included, "I have no worries and the girls look after me very well." Relatives were also complimentary about the service. One relative told us, "When I leave here I know my [relative] is in safe hands" and another told us "Peace of mind, I can leave him here and not worry about anything." All the relatives with whom we spoke told us that any concern, no matter how small was discussed with the management team as soon as it arose. They told us they were encouraged by the registered manager or owner to speak up if they felt their relative's safety was at risk. Staff we spoke with said they felt confident people were always treated well. They had received training in safeguarding vulnerable adults and were able to describe to us how they would identify and act on any concerns. We saw no safeguarding incidents had occurred since the service registered in October 2016, however the registered manager demonstrated a good understanding of the process to follow should concerns be identified. This gave us assurance the correct processes would be followed.

People had risk assessments which identified risks in relation to their health, independence and wellbeing. There were assessments in place which considered the individual risks to people such as choking, nutrition and hydration, skin, mobility and personal care. We saw how one person had been found to be at potential risk of harm from falls. The assessment had looked at factors such as current medication and assessed their mobility in order to put a risk reduction plan in place. Risks associated with skin and pressure sores were assessed. We saw where people were deemed to be at risk new equipment and positioning regimes had been put in place. One relative told us how they were impressed how proactive the new owner had been in ensuring that safety equipment such as hoists and mattresses was modern and suitable for their intended need. Risk assessments also included risks posed to others as a result of people's behaviours that challenged. We saw these assessments were accompanied with behaviour record charts which had the aim of trying to predict when untoward behaviour may manifest itself and thus help to protect others from harm.

Accidents and incidents were recorded, investigated and analysed on a monthly basis to look for any themes and trends. We saw a low number of incidents occurred within the service and the registered manager was committed to continuously reviewing any incidents to reduce the risk of a re-occurrence.

Medicines were administered to people by trained nursing staff. We observed part of the morning medicine round conducted by a nurse. We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure they complied with current legislation and best practice in the administration of medicines. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system.

We inspected medication storage and administration procedures in the home. We found the storage cupboards were secure, clean and well organised. We saw the controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Medicine fridge and room temperatures were taken daily and recorded. The treatment room was locked when not in use.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date. We saw records for people who were prescribed creams included body maps which showed where the cream was to be applied.

We saw evidence people were referred to their doctor when issues in relation to their medication arose. Annotations of changes to medicines in care plans and on MAR sheets were signed by care staff.

We saw all as necessary (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given. We saw care staff recorded the effect of the PRN medicine and where a variable dose was prescribed the dose was recorded.

The nurse we spoke with showed us the medication administration records (MAR) sheet was complete and contained no gaps in signatures. We saw any known allergies were recorded. We asked the nurse about the safe handling of medicines to ensure people received the correct medication. Answers given demonstrated medicines were given in a competent manner by well trained staff.

The provider had compiled protocols for the administration of certain medicines which required specific rules to be observed. For example, we saw protocols were available for the administration of warfarin where the dose is determined by periodic blood tests. We looked specifically for the use of antipsychotic, anxiolytic or antidepressant medicines as interventions for challenging behaviours. We found functional analysis had taken place to identify what appeared to trigger untoward behaviours and trends in behaviour to enable staff to de-escalate situations without the need for 'as necessary' (PRN) medicines.

We carried out a random sample of supplied medicines dispensed in individual boxes. We found on all occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet. We examined records of medicines no longer required and found the procedures to be robust and well managed.

We saw evidence of effective auditing of medicines. The manager conducted audits of MAR sheets and stock control mechanisms. We concluded effective training of well recruited staff, underpinned by effective audit had resulted in the safe and effective administration of medicines.

Sufficient quantities of staff were deployed to ensure safe and timely care. Staffing numbers were carefully planned using a dependency calculation which assessed the number and needs of people using the service. People and relatives told us there were enough staff and that people always received prompt care and assistance when they needed it. Staff also shared this view and said they had enough time to undertake care and support and engage in social activities with people. We observed care and support and saw staff were visible and attentive throughout the day. Staff were available to quickly intervene if people became distressed, ensure people received assistance with their meals and to supervise communal areas appropriately.

People were cared for by suitable staff because safe recruitment procedures were in place and managed by the provider. We saw the recruitment procedures in place which included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and

behaviour. A DBS check allows employers to establish whether the applicant has any convictions that may prevent them working with vulnerable people. We saw the provider had a robust system to check nurses' registration status with the Nursing and Midwifery Council both at the point of employment and as a result of periodic registration.

We completed a tour of the premises and inspected four people's bedrooms, toilets, bathrooms, the laundry and various communal living spaces. Recent improvements had been made to the premises to update décor and floor coverings with further refurbishment work planned. All hot water taps were protected by thermostatic mixer valves to protect people from the risks associated with very hot water. Heating to the home was provided by covered radiators thus protecting vulnerable people from the risk of a burn from a hot surface. We saw fire-fighting equipment was available and emergency lighting was in place. We saw fire escapes were unobstructed. We saw upstairs windows had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows. We found all floor coverings were appropriate to the environment in which they were used; were well fitted and as such did not pose a trip hazard. We inspected records of the lift, gas safety, electrical installations, water quality, pest control and fire detection systems and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested and carried confirmation of the test and the date it was carried out.

We saw a number of practical steps were in place to address the potential risks of cross infection. For example, anti-bacterial gel dispensers were located throughout the home. We observed all staff washed their hands appropriately between tasks and had disposable gloves and aprons to support people with their personal care tasks. We spoke with the cleaner who demonstrated a good understanding of how to keep the home clean. The home used colour-coded mops, buckets and cloths and the cleaner had a thorough understanding of how and where these items were to be used. The service had a written cleaning schedule. Records showed the schedule was delivered. We found the home to be clean and free from mal-odours. The service had received a five star hygiene rating from the Food Standards Agency. This is the highest score that can be awarded and demonstrated food was prepared in a hygienic manner.

Good

Is the service effective?

Our findings

People and relatives with whom we spoke were confident in the competency of the staff supporting them. One relative told us, "Anything I ask the staff about they know without the need to ask someone else or refer to my [relative's] records." Another relative told us "Staff are receiving regular training now, they are learning lots of new things and putting them into practice." Records demonstrated staff received a range of training relevant to their role. Staff described training as "excellent" and said the registered manager was effective in finding and sharing knowledge. They said the training and support gave them the skills needed to undertake their role.

New staff without previous experience completed the care certificate. The care certificate is a government backed training scheme for staff in social care which it is recommended that all staff new to care complete. New staff also had a local induction to the home, ways of working and undertook a period of shadowing so they understood about people and their individual needs.

Existing staff received regular training updates in subjects relevant to their role. In 2016 when the home changed ownership all staff had received an induction to the new service as well as training in subjects such as safeguarding, fire, dementia, challenging behaviour, mental capacity , nutrition, moving and handling, equality and diversity and end of life care. Much of this training was delivered face to face by internal trainers. A further training programme was in place for 2017 and external trainers had been enlisted to provide some of this to ensure staff were kept up-to-date with the latest training and best practice. A number of staff had received 'React to Red' pressure area training from local health professionals and were now responsible for training up other staff within the team. External health professionals had also been used to deliver specialist training such as continence, palliative care, tissue viability and falls.

The registered manager had installed a positive, learning culture within the service, with each staff member being allocated 'champion' for a number of subjects including safeguarding, dementia, nutrition and pressure areas. Staff had researched their champion topics and read National Institute for Health and Care Excellence (NICE) guidance to become knowledgeable about their subjects. This initiative was in its early days with plans for staff to develop notice boards about their subjects, and present training to other staff members twice a year on 'Champions Day' which were to begin in Spring 2017. Staff we spoke with demonstrated they were committed to being part of this initiative. This would help ensure expert skills and knowledge were developed within the service.

We looked at a random sample of staff files. We found all staff met with the manager regularly to discuss their performance and training needs and had annual appraisal meetings. We saw the frequency of supervision meetings were greater in the early part of staff's employment when they needed the most support. Written comments made by staff indicated how much they appreciated the support and encouragement they had received during their induction period. Staff confirmed they received regular supervision and support.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw ten people had DoLS in place, two of which were awaiting the outcome of a renewal application to the supervisory body. We saw where the supervisory body had attached conditions to the authorisation these were being met. For example, one condition required the managing authority to ensure a referral was made to a dietician. We saw the referral was made and a dietician attended within two weeks of the condition being applied.

We saw three people were having their medicines administered covertly. Our inspection of the documentation to create a legal framework to comply with the needs of the MCA and good clinical practice demonstrated the registered manager had an excellent understanding of the requirements. Furthermore, the practice of covert medication administration was under regular review, the outcome of which was recorded in detail. We saw evidence of other decisions being made in people's best interest decisions where they lacked capacity. For example following weight loss to one individual , a best interest process involving the family, health professionals and the registered manager took place to determine the level of investigation and intervention appropriate to the person's best interests

We saw from care records some people had appointed attorneys by way of a lasting power of attorney (LPA) or where people lacked mental capacity, had deputies appointed by the Court of Protection. Care plans recorded where attorneys and deputies had been involved in decision making or where reviews of care plans had been undertaken.

We spoke with the registered manager about the use of restraint. They were able to demonstrate their knowledge and knew the difference between lawful and unlawful restraint practices. We spoke also with the registered manager about the use of bed-rails. Answers we received demonstrated when people had capacity they we consulted on the use of bed-rails and understood the action was proportionate to the potential harm. Where there was a lack of capacity or the person's capacity fluctuated, care records demonstrated family members were consulted before bed-rails were used.

We found some people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place. These had been completed by relevant clinicians. There was evidence of involving family members in the decision. Staff we spoke with had an accurate knowledge of which people had DNACPR arrangements in place.

People and relatives praised the food provided by the home. One person said "Lovely food." People had access to a range of suitably nutritious food. Meals were rotated on a four weekly menu to ensure variety and a balanced diet. Two cooks were employed who prepared food using fresh ingredients on a daily basis. People had access to cereals, toast, porridge and a hot option at breakfast. At lunchtime the kitchen provided people with two choices each day, one of these being a lighter option. If people did not like any of the choices, alternatives could be prepared. The cook explained to us that as the occupancy increased they planned to further develop the menu and broaden the variety and range of alternative options available.

Nutritional risks were well monitored by the home. Nutritional risk assessments were regularly updated and used to formulate detailed nutritional plans. People were weighed at weekly or monthly intervals dependant on the individual risk. Weights were subject to regular audit and review. Where weight loss was identified appropriate measures were taken such as increased weight monitoring, monitoring food intake

and referral to dietician for advice and/or the prescription of nutritional supplements. The cook was aware of people's special dietary needs. For example one person was diabetic so care was taken to ensure they had a healthy diet and they were prepared a low sugar dessert. Other people required their food of differing consistencies and the cook was aware so that food could be prepared in a safe and appropriate way.

We observed the lunchtime meal and found it to be a pleasant experience with people supported appropriately. Food looked tasty and appetising and people told us they enjoyed it. Further improvements were planned to the mealtime experience such as pictorial menu's to assist people's communication and a hot food trolley to reduce the risk of food cooling down on its way from the kitchen.

Relatives said people's health needs were met. This included making appointments to see healthcare professionals when needed. They also said the service was good at detecting changes in people's health. One relative told us how the home was always quick to contact them and talk through any health related concerns. We saw evidence in written records staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GPs, hospital consultants, community nurses, tissue viability nurses, speech and language therapists, dieticians and dentists. We saw the advice of external health professionals was incorporated into plans of care for staff to follow.

Some adaptions had been made to make the environment more dementia friendly. This included clear signage indicating which room people were entering, pictures of people on their bedroom doors and their likes and interests to help them orientate themselves with their surroundings. Further work was planned in this area as part of a refurbishment and upgrade of the premises.

Good

Is the service caring?

Our findings

People and relatives described staff as kind and caring and said people were always treated with a high level of dignity and respect. One relative saying, "They are an excellent set of staff here. I visited many places before deciding I wanted my [relative] to live here and I have never regretted the decision." Another relative said "Very good staff attitude they always seem to be busy helping people."

We observed care and support and saw people were treated with dignity and respect. Staff interacted positively with people and took the time to speak with people in a friendly and approachable manner. Staff took prompt action to calm any distress and used a mixture of verbal and non-verbal communication techniques to comfort people. We saw staff sat with people whilst completing care and support paperwork. This enabled staff to provide people with social interaction, supervision and companionship at the same time as completing vital paperwork. We observed people looked clean, appropriately dressed and presentable. This indicated that their personal hygiene needs were being met by the service.

Staff recognised the importance of ensuring people had privacy if they required it. We saw staff respected people's privacy for example knocking on doors before entering and respecting people and their relatives need for privacy.

It was clear that staff had developed good, positive relationships with people. Information on people's likes, dislikes and life histories had been obtained by the service and were recorded in people's care and support plans. This helped staff provide personalised care relevant to people's individual needs. Staff we spoke with had a good understanding of the people they were caring for, including their interests, likes and dislikes. Each person had a key worker which provided a named contact to develop and maintain a special relationship with care and support arrangements. Staff were clear on the keyworker role and what they did to maintain these relationships.

People and relatives said they felt listened to by the staff and management. This was confirmed by our observation where we saw people were asked what they wanted to do, where they wanted to sit and what they wanted to eat. People and/or their family were involved in making decisions about the care that was received. Relatives told us how they were consulted about their family member's care where the person were not able to make their own decisions and were asked for their opinion on how the care should be provided. All relatives we spoke with told us the staff always kept them up to date with the health and welfare of their family member.

People's care plans made it clear how they liked to be supported. This included their cultural beliefs, gender and spiritual preferences which had been sourced from a life history discussion with people or their relatives. Staff knew the people they were supporting well and spoke knowledgably about their needs and preferences. For example, they knew how people liked to be addressed, if they wanted to go to church and whether they had a preference about the gender of staff supporting them. We found the requirements of the Equality Act 2010 were well understood by the registered manager and enacted by the staff.

We saw one person was without any contact with their family and had little support from friends. Care records demonstrated the registered manager had spoken with the person and as a result organised for the person to be supported with a lay advocate. The person concerned had the capacity to understand their needs but requested someone independent to help them with some decisions they wished to make. We saw the outcome of the advocacy had resulted in the needs of the person being better met. For example, the person had issues with their ability to smoke when and as much as they pleased whilst the staff were trying to encourage a reduction in smoking both on the grounds of health and cost. The intervention of an advocate had resulted in a written consent agreement and the attendance of the person at a smoking cessation clinic.

People's wishes and preferences had been sought with regards to end of life arrangements. Where appropriate people had end of life care plans in place to help ensure people received dignified care at the end of their lives.

Good

Is the service responsive?

Our findings

People received care which was responsive to their individual needs. The people we spoke with and their relatives told us individual preferences were met and were respected. One person with whom we spoke said they were supported to get up in the morning and go to bed when they wanted to. Relatives told us the service was on top of any changes in their relative's health or condition. One relative told us how they were impressed about how good the handover of information between staff was. They told us when they rang up to ask about their relative, staff never failed to be "clued up" and clear about their relative's current condition and any recent changes.

People were assessed as to their risk of being at pressure sores and appropriate plans of care were put in place. Pressure reducing equipment such as air mattresses was put in place and the setting was regularly checked by staff to make sure it remained appropriate. Documented daily skin checks were undertaken and regular repositions were undertaken to reduce the risk of people developing pressure sores. We saw no pressure sores had occurred in the home since the registration in October 2016. Maybe add something about being treatment

People's needs were assessed with theirs and their family's involvement, prior to them moving into the home. One relative told us "They discuss everything with me, care plan and everything." Another person's relative with whom we spoke confirmed they had participated in the initial assessment and had since been involved with any discussion and review of their family member's care and support. Following this assessment, a support plan was developed which was personalised to reflect the person's needs and preferences. The support plans we read were personal to the individual and gave information to staff about people's needs and how they made choices. We saw where people were at risk of harm or may pose risks to others the registered manager engaged relatives and other healthcare professionals in the assessment process. For example, one person had marked cognitive impairment as a result of vascular dementia. They were displaying behaviour and psychological symptoms of dementia (PSD) which included behaviours that challenge and persistent resistance to personal care interventions. The care requirements of this person were carefully considered before offering admission to the home. We saw the person's care needs were kept under regular review to ensure the endeavours of staff to facilitate care were delivered in the least restrictive way possible.

A synopsis care plan for each person who used the service was also in place which provided a summary of their care and support needs for quick reference and also allowed staff to record all care and support interventions. These were well completed evidencing people had received care in line with their assessed needs and plans of care.

Relatives told us there were suitable activities available for people. One relative told us "They try with activities, have all kinds of activities in the afternoon." An activities programme was in place, to ensure a range of activities and opportunities were provided to people on a daily basis. Internal activities included hand massages, games, sing-alongs, reminiscence and film days. In addition, external visits from musical entertainers took place. As well as planned activities, staff participated in activities on an individual basis

with people, such as domino's and arts and crafts. Staff helped people maintain links with the local community, for example assisting people to go out to the shops. At the time of the inspection, care staff undertook these activities with people, although a full time activities co-ordinator was in the process of being recruited. This would allow greater flexibility and variation to the activities provided.

Instructions on how to complain were on display throughout the home and also in the service's statement of purpose which was available in people's rooms. People and relatives told us they could not recall whether there was a formal complaints process to follow should they wish to make a complaint. However, they said they did not have any complaints but felt confident to raise any issues with the staff if they were unhappy about anything. They told us the relatives' meetings were a good arena in which to express any views or comments and the owner encouraged constructive comments to improve the service. They also told us the management team was very approachable and they were confident their complaints or minor issues would be acted on.

Good

Is the service well-led?

Our findings

A registered manager was in place. The registered manager usually worked supernumerary but on the day of our inspection they were the registered nurse on duty due to unplanned absence of a member of the nursing team. We found all notifications such as notification of deaths had been reported to the Commission in line with statutory requirements.

People and relatives all spoke positively about the quality of care provided at the home. Relatives told us how since the new provider had taken over the home, the quality of care and support had increased significantly. One relative told us "I was happy before, but it's a lot better now, manager and owner are both great, care is better, a lot better than 12 months before." Relatives all said they would recommend the service to anyone. Relatives were very complimentary about the registered manager and the way the service was led. Comments included; "[Manager] is the person who makes the service so good," "The manager and owner are really good and always available for us to speak with," and "Registered manager is brilliant manager any concerns can go to her or the provider. I just know we can trust them when taking to her."

The service had been registered since October 2016, with previously the home being owned and managed by a different provider. During and after the change in ownership, we found the registered manager had delivered significant improvement to the service, changing working practices, the culture and ensuring robust documentation and quality assurance systems were put in place. We found the service was organised in a highly effective way. Staff demonstrated to us they were clear about their roles and responsibilities within the service. During each day shift each of the three care workers was allocated five people each to oversee. This helped ensure each person's safety and staff told us this arrangement worked well. Staff praised the registered manager's approach and organisation. One staff member said "A lot better than before, running a lot smoother." The registered manager had delegated a range of responsibilities including undertaking audits, and taking lead responsibilities for subjects such as dementia and pressure care to individual staff. This had empowered and motivated staff. Staff demonstrated they were committed to these additional responsibilities and we saw how they were resulting in increased staff knowledge and effective completion of audits and checks. Staff morale was good and staff told us they received good support from the management team.

Staff and the management team regularly consulted NICE guidelines and incorporated them into working practices. Systems were in place to share good practice with the other homes owned by the same provider to enable good ideas to be implemented.

We saw audit processes were used to measure the quality of the service and provide a reflective manner in which to address issues. We looked at the most recent medicines audits which we found to reflect our own findings on the day of inspection. A range of other audits and checks were undertaken. Care plans were regularly audited and these were regularly picking up discrepancies in documentation, for example inappropriate terminology and non-completion of risk assessments. Following these actions were effectively delegated to nursing and care staff for completion. Audits in areas such as nutrition, dignity and wellbeing, infection control and equipment took place and we saw evidence that these were used to further improve

the service.

Staff meetings were regularly held which were an opportunity to discuss quality issues and make further improvements to the service. The registered manager was required to feed information on the performance of the home such as incidents, complaints and safeguarding into a monthly clinical governance meeting to ensure the provider was aware of how the home was performing and provided a mechanism by which performance and risk could be scrutinised.

Mechanisms were in place to listen to people and use their feedback to further improve the service. Regular 'resident and relative' meetings were held. We saw these were an opportunity for the provider to inform people about changes in the home, and ask them to feedback on any care quality issues as well as areas such as food and activities. The home's improvement plan was also discussed with relatives to keep them informed of development progress. People and relatives views were also sought through quality surveys. A recent food satisfaction survey was in the process of being undertaken. The registered manager and cook told us that once all results were received the feedback would be used to make changes to the menu.