HC-One Limited

Orchard Mews

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 15 November 2016. We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

We last inspected Orchard Mews in August 2015. At that inspection we found the service was in breach of its legal requirements.

Orchard Mews is a purpose built care home that provides personal and nursing care to a maximum of 36 older people, including people who live with dementia.

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.

We found improvements had been made to ensure the safe care and treatment of people. People told us they felt safe and there were enough staff on duty. Staff had more time to interact and spend time with people and not just when they carried out tasks. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Regular checks took place to ensure the building was safe and well-maintained. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Appropriate training was provided and staff were supervised and supported. Staff had received training and had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines in a safe and timely way.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff knew the needs of the people they supported to provide individual care. Most records were in place that reflected the care that staff provided. We have made a recommendation about care plans.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. Activities and entertainment were available for people. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

Staff and people who used the service said the registered manager was supportive and approachable. People told us they felt confident to speak to staff about any concerns if they needed to. Communication

was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

People had the opportunity to give their views about the service. Feedback was acted upon in order to ensure improvements were made to the service when required. The environment was being refurbished and it was bright and promoted the orientation and independence of people who lived with dementia. The provider undertook a range of audits to check on the quality of care provided.

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 were kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm. Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Regular checks were carried out to ensure the building was safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

The environment was well-maintained and was designed for the orientation of people who lived with dementia.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. Care plans were in place but they did not provide detail of how people's care should be provided. We have made a recommendation about care planning.

There was a variety of activities and entertainment to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was readily available to give advice and support. The registered manager and management team promoted the delivery of more person centred care for people.

People were complimentary about the registered manager and staff team. They told us there was an open and positive atmosphere in the home and people and relatives were consulted about the running of the home.

The home had a quality assurance programme to check on the quality of care provided.

Orchard Mews

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.

This inspection took place on 15 November 2016 and was unannounced. The inspection team consisted of one adult social care inspector and an expert by experience.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service.

During this inspection we carried out observations using 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 communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with nine people who lived at Orchard Mews, four relatives, the registered manager, the area manager, one registered nurse, six support workers including one senior support worker, two members of catering staff and two visiting care professionals. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for eight people, recruitment, training and induction records for five staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used

the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

At the last inspection we had concerns there were not enough staff on duty to provide safe and individual care to people.

At this inspection we found that improvements had been made as there were sufficient staff available to meet the current care and support needs of the people and to look after them safely. Due to their health conditions and complex needs not all people were able to share their views about the service they received. Other people told us they were safe and staff attended to them promptly. Their comments included, "Oh yes, I feel very safe here, thank you" , "I feel safe here, they [staff] run around and look after you" and "They're always popping in to see how you are." Relative's comments included, "People are 100% safe and there are always enough staff", "I was apprehensive and worried before [Name] moved here, but they [Name] likes it here and we know they are happy and safe."

We were told staffing levels were determined by the number of people using the service and their needs. There were 37 people who were living at the home. Staffing rosters and observations showed during the day on the top floor eight people, were supported by two support workers including a senior support worker. On the middle floor 15 people were supported by a registered nurse and five support workers, this included a support worker who provided one-to-one support to a person. On the ground floor 14 people were supported by three support workers, including a senior support worker. These numbers did not include the registered manager who was also on duty each day. Overnight staffing levels included one nurse and four support workers.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the registered manager. Between November 2015 and October 2016 33 safeguarding alerts had been raised, some had been incidents between people who used the service. All alerts had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team.

Staff had an understanding of safeguarding and knew how to report any concerns. Records showed and staff confirmed they had completed safeguarding adults training. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the registered manager. Staff members' comments included, "I'd report any concerns to the senior on duty" and "If I had any concerns I'd report it to the nurse straight away."

Risk assessments and their evaluations were up to date. They were regularly evaluated to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for losing weight, choking, falls and pressure area care. Records contained information for staff on how to

reduce identified risks, whilst avoiding undue restrictions. For example, a falls risk assessment included measures to minimise the risk of falls.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plans were reviewed monthly to ensure they were up to date. These were used in the event of the building needing to be evacuated in an emergency.

People were supported with their medicines safely. Medicines were given as prescribed. We observed a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. As they administered the medicines they explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Systems were in place to ensure that all medicines had been ordered, stored securely, administered safely and audited. This included for controlled drugs, which are medicines which may be at risk of misuse. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Relatives told us they were kept informed by the staff about their family member's health and the care they received. Relatives' comments included, "Care plans and medicine are always discussed, staff always ask if everything is okay, or if there are any problems", "Staff always inform us of anything that happens to [Name], like anything the doctor has said", "We are always involved in [Name]'s treatment, they [staff] tell us" and "I'm kept informed about [Name]'s health and if there's any change in their condition."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), psychiatrists, a speech and language team (SALT) and psychiatrists. A relative told us, "A chiropodist comes in." Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals. We spoke with one visiting health care professional during the inspection. They told us people were referred straight away if there were any concerns about their health and staff followed their advice and guidance. They also said staff were caring and communication was good. They commented, "I'm impressed with what I've seen here. They [Staff] are very pro-active. It's very refreshing, they're very organised." We were told a local General Practitioner held a weekly clinic at the home to review people's health needs and to make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital.

Systems were in place to ensure people received drinks and varied meals at regular times. Meals were well presented and people told us they had a choice at meal times. Peoples' comments included, "There is lots of choice with food and I always get enough" and "The food is okay but it's not like at home." A relative commented, "There is plenty of variety in the food, and plenty of it." We looked around the kitchen and saw it was well stocked with fresh, frozen, home baked and tinned produce. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They explained how people who needed to increase weight and to be strengthened would be offered a fortified diet and how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. The cook told us they received information from nursing staff when people required a specialised diet. Written information was available in the kitchen to inform any cook of the dietary preferences and specialised diets for people when the regular cook was not available. For example, diabetic, vegetarian and soft or pureed diets.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. Snacks were also available in communal areas for people to help themselves. These included snacks such as chocolate bars and biscuits to help increase the nutrition of people who were at risk of poor nutrition and weight loss.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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 any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of and had received training in the MCA and the related DoLS. The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The registered manager told us 22 applications had been authorised, three people did not require one and other applications were being processed by the local authority.

Staff had a good understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. Peoples' care records showed when 'best interest' decisions may need to be made. People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

A programme of refurbishment was taking place around the home and communal areas had been decorated. The environment was better designed, since the last inspection, to ensure it was stimulating and therapeutic for the benefit of people who lived there. Lighting in the top floor lounge had been replaced to make the room brighter. There were areas of visual and sensory stimulation to help maintain the involvement and orientation of people who lived with dementia. There were displays and themed areas around the home to stimulate and remind people as they walked around. Communal areas and hallways had decorations and pictures of interest, including memorabilia to help people reminisce. There was appropriate signage around the building to help maintain people's orientation. Lavatories, bathrooms and bedrooms had pictures and signs for people to identify the room to help maintain their independence.

Staff told us and their training records showed they had opportunities for training to understand people's care and support needs and they were supported in their role. Staff comments included, "I want to do end of life care training" and "We can use the computer to do on-line training."

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. A staff member commented, "I shadowed another member of staff for three days as part of my induction when I started" and another staff member told us, "I did the Care Certificate as part of my induction."

The staff training record showed all staff were kept up-to-date with safe working practices. The registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. The training gave staff some knowledge and insight into people's needs and this included a range of courses such as dementia care, falls awareness, customer care, management training, nutrition and hydration, creating therapeutic relationships, distressed behaviour, person centred

care, team working, promoting healthy skin, dignity awareness, equality and diversity and mental capacity. Staff also had the opportunity to study for a National Vocational Qualification (NVQ) now known as the diploma in health and social care.

Staff told us and their training files showed they received regular supervision from the management team, to discuss their work performance and training needs. Staff members' comments included, "I have supervision every three months" and "The registered manager does my supervision." Staff told us they were well supported to carry out their caring role. Staff said they could also approach the registered manager at any time to discuss any issues. They also said they received an annual appraisal to review their progress and work performance.

Staff told us communication was effective to keep them up to date with people's changing needs. A handover session took place, between senior staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. The nurses then cascaded the information to support workers. This was to ensure staff were made aware of the current state of health and wellbeing of each person. We saw handover records contained information about the care provision and the state of well-being for each person over the previous 12 hours. Staff told us the diary and communication book also provided them with information. Their comments included, "Communication is good" and "We're given information when we come on duty, if anyone is ill."

Good

Is the service caring?

Our findings

People who lived in the home and their visitors were all very positive about the care provided by staff. Peoples' comments included, "I feel very lucky to be here because they look after me", "Staff are very helpful and they give you all their attention, they are all so nice, I don't know where they get such lovely people from", "I'm looked after very well", "I'm very pleased with the staff, they keep me clean and listen to me and help me", "It's fine here", "The staff here are kind and patient," "Staff are alright, they look after you", "It's a great set up here, we're all lucky to be here" and "I'm quite content here, I was on my own at home, rattling around an empty house." Relatives' comments included, "What I like about the place is that it's not formal, you feel comfortable as soon as you walk in", "Staff are very welcoming", "Staff are brilliant, kind and patient, I can't fault them" and "People are well cared for."

During the inspection there was a relaxed atmosphere in the home. Some people had complex needs and we saw staff interacted well with people who we saw were relaxed with them. Staff were enthusiastic and knowledgeable as they described people's needs. They engaged with people and spent time with them when possible. People were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. Staff asked the person's permission before they carried out any intervention. For example, as they offered people drinks or assisted them to move from their chairs. Staff explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

People's privacy and dignity were respected. People told us staff were respectful. We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors. Most people sat in communal areas but some preferred to stay in their own room. People's care plans recorded their preference for gender of carer to carry out any aspects of personal care with them. For example one care plan recorded, '[Name] requires a female staff member to help with all aspects of personal care.' A relative commented, "Staff look after [Name]'s privacy and dignity." Staff received training to remind them about aspects of dignity in care and a dignity champion was also appointed from the staff team to promote dignity within the home.

We saw people who lived with dementia were encouraged to make a choice and be involved in decision making. For example, with regard to meals, drinks and other activities of daily living. Pictorial menus about food were available to help people make a choice of food. Staff gave examples of asking families for information and showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. People told us they were offered choices and involved in daily decision making about other aspects of their care. For example, activities, menus and bathing. One person told us, "There is lots of choice with the food." Care records provided information for staff that detailed people's level of comprehension and how they could be enabled to make a choice. Examples included, '[Name] can express their likes and dislikes' and 'Name has some

capacity to make decisions about what they'll eat or wear.' We observed people could have a long-lie in bed and were assisted to get up when they wanted.

Care plans provided information about how people communicated. For example, one care plan recorded, '[Name] can express happiness.' Staff described how they supported people who did not express their views verbally. Staff observed facial expressions and looked for signs of discomfort when people were unable to say, for example, if they were in pain.

We observed the lunch time meal. The meal time was relaxed and unhurried. Tables were set for three or four and staff remained in the dining areas to provide encouragement and support to people. Staff interacted with people as they served them. They regularly asked people whether the food was sufficient and enjoyable. Staff provided prompts if required to people to encourage them to eat, and they did this in a quiet, gentle way. For example, "Would you like some more" and "Do you want another drink?" We observed people were given a choice of meal and staff verbally described and showed people what was available.

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. We were told the service used advocates, such as an Independent Mental Health (IMHA) advocate as required in the process where people did not have a relative. Advocates can represent the views for people who are not able to express their wishes. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Good

Is the service responsive?

Our findings

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition, communication, pressure area care, mobility and falls and personal hygiene. Evaluations were detailed and included information about peoples' progress and well-being.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. Care plans provided some information for staff about how people liked to be supported. For example, some care plans for personal hygiene stated, '[Name] likes a bath or a shower at least twice a week' and '[Name] needs support from one to two staff with their personal care.' However, care plans were not all broken down to provide details for staff about how the person's care needs were to be met. They did not all give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not detail what the person was able to do to take part in their care and to maintain some independence.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example, if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the community mental health team. Staff told us they followed the instructions and guidance of the community mental health team for example to complete behavioural charts or vocalization charts if a person displayed distressed behaviour.

Some records were in place for the management of behaviour which could be described as challenging. Care plans provided some information which detailed peoples' care and support requirements if they became distressed or agitated for example, one care plan stated, ''[Name] needs the assistance from two to four staff members during personal care, depending upon their behaviour and mood.' However, they did not contain details of what might trigger the distressed behaviour and what staff could do to support the person. This guidance would help ensure staff worked in a consistent way with the person, to help reduce the anxiety and distressed behaviour.

We recommend the registered manager seeks guidance about developing more person centred care plans.

Other information was available in people's care records to help staff provide care and support. For example, '[Name] likes to go to the hairdresser two–three times a month' and 'Ensure [Name] is in an upright position when eating and drinking.' Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff

intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

An activities organiser was employed and when they were not on duty staff carried out activities with people. Lounges contained reading books and puzzle books, games and DVDs for people to use. We saw some staff played cards and dominoes with people. A programme advertised activities that were available and this included, board games, quizzes, pamper sessions, reminiscence, newspapers, movie afternoons, armchair exercises, music therapy and crafts. The back garden was ornate and we were told it had been very colourful in the summer as some people enjoyed gardening. One person told us, "The new garden is glorious." We saw the gardening project had taken place due to some feedback from residents and relatives about the garden areas. This showed the service took action as the result of people's comments. One to one activities and people's previous hobbies and interests were promoted. For example, the bedroom of a person who was confined to bed had photographs of the garden on their wall as they loved gardening and had been unable to go out into the garden. We were told they also liked butterflies and stained glass butterflies had been attached to their window. Entertainment and concerts also took place. We saw a variety of seasonal entertainment was arranged for over the Christmas period including a staff pantomime. The cook also told us, "We're going to make gingerbread houses for a competition." The hairdresser visited weekly and a local member of the clergy visited regularly. Arrangements were also in place to meet other religious needs as a 'Special Minister' visited to bring Holy Communion to a person. A travelling old fashioned sweet shop also visited regularly. Transport was available and people had the opportunity to go out on trips. Staff told us people had been on a recent trip to see some reindeers in Stockton. One relative commented, "There are trips out and we are involved if we want to be." The registered manager told us of links with the community whereby local college and school children visited. We saw local school children were to visit over the Christmas period.

Regular meetings were held with people who used the service and their relatives. The registered manager told us meetings provided feedback from people about the running of the home. Meeting minutes from October 2016 showed topics discussed included, fund raising, laundry, housekeeping and social events that were to take place in the home in October and November. Discussion also took place about changing the time of the meeting to the afternoon to enable more relatives to attend.

People said they knew how to complain. One person commented, "I have no complaints at all" and a relative told us, "Any complaints I can go straight to [Name] the manager, not that I've had any." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and we saw three complaints had been received in the last eight months and they had been appropriately investigated and resolved. We saw several compliments had been received from relatives of people who used the service thanking staff for the care provided.

Good

Is the service well-led?

Our findings

A registered manager was in post and they had registered with the Care Quality Commission in May 2016. The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

The registered manager assisted us with the inspection, together with the area manager. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and provider's representative were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The registered manager had been appointed within the last year. They were enthusiastic and had many ideas to introduce to promote the well-being of people who used the service. Staff we spoke with spoke positively about their management and had respect for them. Staff commented, "It's enjoyable working here", "Things have improved" and "If you need something the office door is always open." The registered manager told us they had introduced changes to the service to help its' smooth running and to help ensure it was well-led for the benefit of people. They responded quickly to address any concerns that may be raised.

The registered manager promoted an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Staff and relatives were also involved and encouraged to give ideas about the running of the home. A variety of information with regard to the running of the service was displayed on noticeboards in the home to keep people informed and aware and this included staff roles, safeguarding, falls information, advocacy and forthcoming events.

The atmosphere in the home was lively and friendly. People told us the atmosphere was warm and relatives and visiting professionals said they were always made welcome. Staff, people and relatives said they felt well-supported. Their comments included, "The atmosphere is fantastic", "[Name] the registered manager is available and ready to listen", "[Name], the manager is very caring", "Staff always ask us if everything is okay" and "The manager is approachable and very nice."

The organisation had an incentive scheme to reward staff for their performance and outstanding care to people who used the service. Staff were nominated by visitors, management and their peers and were presented with a gift voucher and their picture was advertised in the reception area of the home and newsletter to make people aware of their achievement. There were opportunities for personal development for staff and career progression. The organisation had introduced the nurse assistant post and senior support staff had the opportunity to apply for a position. After appointment they received intensive training and were mentored by a member of nursing staff for some months. Staff spoken with were enthusiastic and very positive about the opportunity. Apprentices and other staff also had opportunities for training and advancement.

Staff told us communication was good and we saw staff meeting minutes to show staff meetings took place.

These included daily head of department meetings and regular nurse and support staff meetings. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Staff members told us meeting minutes were made available for staff who were unable to attend meetings. Meeting minutes from September 2016 showed topics discussed included infection control, compliments and staffing rosters. A staff member told us, "Staff meetings do happen."

Auditing and governance processes were robust within the service to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. All audits showed the action that had been taken as a result of previous audits. A weekly risk monitoring report that included areas of care such as safeguarding, complaints, pressure area care and serious changes in a person's health status was completed by the registered manager and submitted to head office for analysis.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. Monthly audits included checks on people's dining experience, medicines management, care documentation, training, kitchen audits, accidents and incidents and nutrition. Three monthly audits were carried out for infection control, falls and health and safety. A financial audit was carried out by a representative from head office annually. We were told monthly visits were carried out by a representative from head office who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the registered manager to ensure they had acted upon the results of their audits. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned. For example, we saw a recent call bell audit identified there were 17 occasions where it took staff longer than three minutes and thirty seconds to answer a call bell. As this was considered too long the follow up action was to speak to staff members concerned and review the person who rang the bell. Other audits included checking complaints, weight charts, nutrition and hydration, safeguarding and staff files. Records showed the registered manager had identified some weight loss with people and so they had introduced a system so it was easier to monitor the person's weight and records were colour coded according to risk. Additional fortified drinks had also been introduced.

The registered manager told us the registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to people who used the service and staff. Surveys had been completed by people who used the service in June 2016. We saw the results had been analysed and feedback was advertised in the home showing what action was to be taken as a result of the survey. From the 16 respondents 31% thought the overall impression of the home was outstanding and 63% rated it as good and 6% as requires improvement. Comments included, 'The care home environment requires improvement.' The organisation had advertised the action taken which was, 'The dining rooms and lounges have been repainted, and new furniture arriving.' Future action included 'Care home is due for refurbishment in 2017. To continue to renew items as required.' As the result of feedback about 'the standard of meals needed to be improved' action taken included 'Met with the cook to discuss menus and meals, cook attended residents meeting to collect ideas and to continue to carry out dining experience survey and to continue to discuss at meetings.' Therefore the service monitored the quality of care that people received and action was taken in response to their feedback.