Care Quality Commission

Tamaris Healthcare (England) Limited

The Laurels Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The Laurels Care Home is registered to provide nursing and personal care for up to 55 older people, although following conversion of some rooms there are only 50 bedrooms. The home provides dementia care on the first floor and nursing care on the ground floor (although people may also have some cognitive decline on this unit). At the time of this inspection there were 47 people living in the home.

The last inspection of this home was carried out on 26 June 2014. The service met the regulations we inspected against at that time.

The home had a registered manager who had been in this role at The Laurels for three years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

During this inspection we found one breach of regulation which related to the management of people's medicines. This was because the provider's arrangements with a pharmacist meant people's medicines had not been delivered to the home in a timely way. Some people had no stock of their medicines for up to four days.

You can see what action we told the provider to take at the back of the full version of the report.

People and their relatives were positive about the service. They felt the care in the home was "good" and that the home was "a safe place" to live. For example, one person commented, "I am happy in this home. The staff are so helpful and will do anything for me." Staff were clear about how to recognise and report any suspicions of abuse.

There were enough staff on duty to support the people who lived there. The staffing levels and skill mix throughout the day and night was suitable to meet people's needs. The provider carried out checks to make sure only suitable staff were employed.

People and relatives we spoke with felt staff had the right skills and competencies to provide the right support. One relative commented, "The staff know how to care for and communicate with my [family member]." Staff had the relevant training and support to care for people. Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision.

Health care professionals said the staff cared for people in a competent, effective way and responded appropriately to any changes in people's well-being. People were supported to eat and drink enough and they had choices about their meals.

People and their relatives felt the staff were "caring" and "friendly". For example one person told us, "This is a nice place to live. The staff are caring and helpful, the food is good, and there are things to do if I want to." People were treated with kindness, patience and dignity. Their individual choices were promoted and their privacy was respected.

Staff in all roles talked with people as they carried out their jobs in the home, including catering and housekeeping staff. A member of housekeeping staff told us, "This is people's home and we try to make it as homely as possible." People and relatives told us there was a good range of activities at the home, including lots of social events and pet therapy.

People had information about how to make a complaint or comment and these were acted upon.

People received personalised care. People had been individually assessed and their care was planned to make sure they got the right support to meet their specific needs. Staff were knowledgeable about people's history as well as their likes and dislikes. A healthcare professional told us, "The staff know people's needs very well."

People and their relatives told us they talked with the staff and the registered manager frequently and had opportunities to comment on how it was run. Visitors described this as a "well run" home

The healthcare professionals we spoke with commented that the service was "effective and well managed". The provider had a quality assurance programme to check the quality of the service. This meant the home continued to improve.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. There had been delays in medicines being delivered to the home so some people were without their medicines for up to four days.

People said they felt safe living at the home and were comfortable with the staff who supported them.

There were sufficient staff to meet people's needs. The home only employed staff who had been vetted to make sure they were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective. Staff had had regular training, supervision and annual appraisals so they were competent in their roles.

People felt their needs were met and were positive about the support they received from staff. People were supported to eat and drink enough to maintain their nutritional health.

Staff understood how to apply Deprivation of Liberty Safeguards (DoLS), where applicable, to make sure people were not restricted unnecessarily, unless it was in their best interests.

Is the service caring?

Good

The service was caring. People felt staff were caring, helpful and friendly. Staff of all roles engaged with people in a positive way.

Staff understood how to support people in a way that upheld their dignity and privacy.

People made their own choices about how they spent their day, where they dined and whether to take part in events at the home.

Is the service responsive?

Good

The service was responsive. People's care records included clear information and guidance for staff to make sure each person's specific needs were met. Staff were familiar with people's individual preferences.

There were meaningful activities for people to participate in, either individually or in groups, to meet their social care needs.

People knew how to make a complaint or raise a concern. They were confident these would be listened to.

Summary of findings

Is the service well-led?

Good

The service was well-led. People were asked for their views and suggestions about the service.

There was a registered manager who had been managing the home for nearly three years.

People's safety was monitored and the provider checked the quality of the care at the home.

The Laurels 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.

This inspection started on 27 October 2015 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist adviser and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A second visit was carried out on 28 October 2015.

Before our inspection, we reviewed the information we held about the home. We contacted commissioners and also the safeguarding team of the local authority before the inspection visit to gain their views of the service provided at this home. We asked healthcare professionals for their views of the service including dietitians, speech and language therapist and a podiatrist. We contacted the local Healthwatch group to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 16 people living at the home and 11 relatives and other visitors. We spoke with the registered manager, deputy manager, a nurse, three senior worker, two care workers, housekeeping and catering staff and an activity staff member. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of eight people, the recruitment records of three staff members, training records and quality monitoring reports.

Requires improvement

Is the service safe?

Our findings

We looked at how people's medicines were managed by the home. We found several people had not received their medicines for a period of one to four days during 12-16 October 2015. For example, medicines administration records reported medicines as "not arrived as yet" or "not available" or "out of stock". These included medicines for pain, blood pressure and anxiety. The registered manager told us this was because there had been delays in getting people's medicines from the pharmacy due to issues with the Electronic Prescribing System (EPS). The EPS enabled GPs to send prescriptions electronically directly to the pharmacy. However this meant several people were without their prescribed medicines during that time, which was unacceptable.

The registered manager said the pharmacist had not delivered medicines in a timely way, so people's medicines had run out of stock before the next batch was delivered. However it was the provider's responsibility to make sure that the systems it used to manage people's medicines meant they received their medicines in the right way and at the right time. Some people were without pain relief during this period, including prescribed paracetamol. However staff had not attempted to obtain 'over-the-counter' paracetamol and administer it as a homely remedy in liaison with the person's GP. Also, the failure to provide medicines for this number of people for the length of time met the regionally-agreed threshold for a safeguarding adults' referral. The registered manager agreed this should be reported to the local safeguarding authority and to the authorities which commission placements at this service.

There was no clear guidance for supporting individual people with 'when required' (PRN) medicines. For example some people, who were unable to express pain due to their cognitive decline, were prescribed 'when required' paracetamol. The PRN forms stated the paracetamol should be given 'for pain' but did not describe how each person might present if they were in pain, so staff may not have a consistent approach to the administration of these medicines.

In discussions staff told us that the EPS system meant different people's medicines were delivered on different days and the system was a significant challenge for senior staff. They stated it could take several days and phone call prompts to get new people's medicines delivered. We observed staff spent up to an hour ringing both the GP and the pharmacist to track down where one person's prescription was and to chase the pharmacist into delivering the medicines.

This was breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Once medicines were received into the home they were appropriately stored and administered. Medicines were given from the container they were supplied in and we saw staff explain to people what medicine they were taking and why. Staff also supported people to take their medicines and provided them with drinks, as appropriate, to ensure they were comfortable in taking their medicine. The staff member remained with each person to ensure they had swallowed their medicines.

Staff were responsible for conducting daily and weekly monthly medicines audits to check that medicines were being administered safely and appropriately. The arrangements for managing controlled drugs, which are medicines which may be at risk of misuse, were safe. Staff had annual competency checks to make sure they were capable and knowledgeable in managing medicines in the right way.

All the people and visitors we spoke with felt the care in the home was "good" and that the home was "a safe place" to live. For example, one person commented, "I am happy in this home. The staff are so helpful and will do anything for me." A relative told us they were, "impressed and relieved" by the safety and quality of the care provided. The reception area had a lot of information for people, relatives and other visitors about safeguarding and how to report any concerns.

Staff told us and records confirmed that they received training in safeguarding adults. They were able to describe how they would report any concerns, and had confidence that these would be dealt with. Staff told us the service was "a safe place" and "a very safe home". There was written information around the home for people, visitors and staff about the how to report any safeguarding concerns including the contact details of the local authority which takes the lead on any safeguarding matters. Commissioners told us they had no current concerns about the service.

Requires improvement

Is the service safe?

There were risk assessments in place for each person, where appropriate, based on their assessment of needs. This meant risks had been identified and were being minimised to keep people safe. Risk assessments included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. There were also risk assessments about the likelihood of pressure ulcers developing or to ensure people were eating and drinking enough. The risk assessments were reviewed each month. The provider also had a computer-based reporting system in place to analyse incident and accident reports in the home. This was to make sure any risks or trends, such as falls, were identified and managed.

A monthly falls analysis was carried out to check if anyone had significant increase in falls so they could be reviewed. Preventative measures were also in place, such as a referral to falls clinic, fall sensor mats in the bedrooms and footwear being checked for suitability. The registered manager also kept a client checklist which was a monthly report about any changes in risk to people such as pressure care and weight loss.

The provider employed a full-time maintenance member of staff who carried out health and safety checks around the premises, including fire safety and hot water temperature checks. It was good practice that the home had a 'grab file' for any staff member to use in the event of an emergency in the home. There were contingency arrangements in place for emergencies, such as what to do and who to contact in the event of a flood, fire or staff absence. There were also personal evacuation plans about how to support each person to leave the building in the event of an emergency.

We looked at whether there were sufficient staff to care for people in a safe way. People and their visitors felt there enough staff on duty and they were very visible around the home. People told us call bells were answered quickly. On the few occasions they rang during this visit they were answered quickly. A health care professional told us, "There seem to be enough staff when I visit and a low turnover of staff."

The provider used a staffing tool, called CHESS, to determine the staffing levels. The tool used the dependency levels of each person (for example, if they had mobility needs or were cared for in bed) to calculate the number of care and nursing hours required throughout the day and night. The staffing tool indicated that the staffing levels provided at The Laurels were sufficient.

Daytime staffing for the 23 people living on the ground floor nursing unit was a nurse, a senior healthcare assistant, and three care workers. Staffing for the 24 people living on the first floor dementia unit was two senior care workers and two care workers. Night time staffing was one nurse, one senior and three care workers. Staff told us, and staff rotas confirmed, this was the typical staffing complement for the home.

There were vacant posts for registered nurses (one full-time day post and one full- time night post). One post had been filled, subject to satisfactory checks being received. In the meantime, the provider was having to use agency nurses to cover six full-time shifts each week. The registered manager tried to arrange for the same agency nurses each week to provide some consistency of care. People and their relatives told us the service was not as personalised when agency staff were on duty.

We looked at the recruitment records of three new members of staff. We found that recruitment practices were thorough and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. The provider carried out monthly checks to make sure that nursing staff were registered with the Nursing and Midwifery Council (NMC). This helped to make sure people received care and treatment from nursing staff who met national standards and abide by the professional code of conduct. This meant people were protected because the home had checks in place to make sure staff were suitable to work with vulnerable people.

Good

Is the service effective?

Our findings

People told us they felt staff were knowledgeable about their needs and were always asking if they were alright. One relative commented, "My [family member] came in here supposedly for end of life care following a severe stroke, but they have improved immensely. The staff know how to care for and communicate with my [family member]."

Staff also felt they met people's needs. One staff member told us, "We look after people well. We do really good handovers so the next shift coming on knows exactly how every person has been." We saw that handover records included information about people's health, moods, behaviour, appetites and the activities they had been engaged in. This meant staff were aware of the current state of health and well-being of people.

Staff told us they felt well trained and supported in their role. For example, one care worker told us, "The manager is always doing training sessions, like end of life and person centred care. We've even done training where we've been the resident with glasses on covered with Vaseline so we couldn't see." This meant staff had had training that helped to understand the experiences of a person receiving care with poor sight.

Staff told us, and records confirmed, they received necessary training in health and safety matters, such as first aid, fire safety, food hygiene and infection control. The provider used a computer based training system for each staff member to complete annual training courses, called e-learning. The home provided care for people living with dementia and staff had had training in dementia awareness and distress reactions (that is, how people might behave if they were upset or anxious). All care staff, except new staff, had a suitable care qualification such as a diploma or national vocational qualification in health and social care. Nurses had suitable training in nursing tasks such as catheter care, venepuncture and anaphylaxis. New staff received induction training before working with people on their own.

Staff confirmed they had supervision sessions with a line supervisor every two months and an annual appraisal. This gave them the opportunity to discuss any training and development needs, as well as the care of the people who lived there. The supervision sessions included clear discussion about expected practices and standards of care.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The appropriate assessments had been carried out at this home and, where required, authorisations were in place for people who required these safeguards. This meant the provider had followed the requirements in the DoLS. Staff had training in MCA and DoLS. People's care records identified where they could make decisions, or where they needed support from other people, including advocates, for more complex decisions.

Staff understood the importance of obtaining people's consent to their care. For instance, asking people for their permission before supporting them with their mobility, using equipment or at mealtimes. People had 'medicine capacity' assessments in place to record if they were able to administer their medicines independently or needed support. At the time of this inspection no-one self-administered their medicines.

The service had recently achieved the silver standard of the PEARL Accreditation Scheme. (PEARL stands for Positively Enriching And Enhancing Residents Lives.) The PEARL programme is an accreditation programme specifically designed by Four Seasons Health Care to ensure

that services provide the most up to date training about communication and interventions for people with living with dementia.

The first floor unit provided accommodation for people living with dementia. There were lots of items of visual and tactile interest for people around this unit, such as themed areas and reminiscence artefacts. There were visual signs for different rooms and coloured doors to bathrooms and toilets for people to find their way around. There was a popular sitting area in the main corridor so people could see who was coming and going or to have a rest stop if they were walking around. This meant the home had some design features that supported people living with dementia.

People were very complimentary about the quality and choices of the meals at the home. People talked about "good, home-made food" and told us the catering staff were "lovely cooks". One relative commented, "We know the food must be very good because [my family member] is a very picky eater but says the food is wonderful!"

We spent time with people over a lunchtime meal on both floors. The food was of good quality. There were two hot main dishes and a choice of desserts. Staff asked people after breakfast which choice they would like for lunch. One person commented, "The food here is very good and the cook is so helpful. She will do other things if you wish."

There were photo menus in dining rooms to help people decide. There were soft foods for people who needed their meals prepared in this way. People were served their meal to their individual preference. For example one person did not like gravy and staff were very aware of this. One person did not eat meat so they were always offered fish or vegetarian options. During meals and at intervals through the day people were offered a variety of drinks including cold drinks, tea and coffee. There were also cold drinks available in people's rooms.

People who needed physical assistance to eat their meal were supported in a sensitive and engaging way. People who needed verbal reminders were encouraged in a supportive way. Meals were taken to people who were bedfast or preferred to eat in their rooms. The dining rooms on both floors were bright, spacious and a pleasant place to dine.

People's nutritional well-being was assessed and kept under review. Records were kept if people required their food or fluid intake to be monitored to make sure any health needs were identified. The nursing and senior staff used these to calculate people's daily amounts of food and drink. People's weight was recorded on at least a monthly basis, unless they were at risk of poor nutrition when it was recorded more frequently. Dietetic services told us they had, "no concerns about the quality of care to patients at The Laurels".

Relatives felt people were supported with their health care needs. They told us they had been contacted by home staff if their relative was ill. People's care records showed when other health professionals visited people, such as their GP, dentist, optician and dietitian. A visiting podiatrist told us the staff were pro-active in flagging up any changes and responded well to any guidance regarding treatment options for people.

Records showed that the relevant people were involved in decisions about a person's end of life choices. When a person could no longer make the decision themselves, we saw that an 'emergency health care plan' was in place that showed a 'best interest' meeting had taken place with the person's family and the GPto anticipate any emergency health problems. We saw an advanced care planning assessment and end of life care plan for people where appropriate. This meant healthcare information was available to inform staff of the person's wishes at that important time, to make sure their final wishes could be met.

Throughout the care records we viewed there was evidence of involvement with other health and social care professionals. The home was part of a local community health care project, called the Coalfield Initiative. The initiative aimed to improve primary care and nursing care in care homes and to reduce admissions and readmissions to urgent care. Previously, as part of the pilot a GP and community nurse had carried out weekly visits to the home to check people's health care needs. Unfortunately this element of the project was "on hold", but the practice nurse was still available to provide telephone support and prescriptions for antibiotics.

Good

Is the service caring?

Our findings

People had many positive comments to make about the "caring" and "friendly" staff. For example one person told us, "This is a nice place to live. The staff are caring and helpful, the food is good, and there are things to do if I want to."

A relative told us, "My [family member] initially came in for a few weeks of respite following a spell in hospital. We do not live locally but the care is so good and we were impressed with the home so we decided that this was the right place for him." Another relative commented, "The staff are lovely. They're very welcoming and friendly towards residents and to visitors."

A healthcare professional told us, "It feels more like a person's own home than a care home. The staff know people's needs very well. The staff always engage with people in a nice way, even if they've got lots of other things to do – you can tell the people are the priority." Another health care professional commented, "During my visits, I have seen generally good levels on compassion.

In general, the carers know the residents well, I have seen good rapport with residents and good examples of kindness, compassion, dignity and respect."

We saw people were supported in a way that upheld their dignity. For example when people asked to go to the toilet they were taken straight away and their privacy was respected. People were also supported in a way that did not compromise their independence. For example one person was trying to walk on their own with a walking frame and made it clear that this was their choice. Staff stayed beside the person just in case they became unsteady but when the person arrived where they wanted to be staff praised them for their achievement.

Around 20 staff across all roles had completed a training video on 'dignity' and had provided a written reflective account of what they had learned from this session. Some staff said it had "moved them to tears" and made them want to make sure that everyone was always treated with dignity. The staff group had also completed 'residents' experience' training as part of the home's PEARL award. This involved spending part of the day in a bed with rails or being physically fed by other staff so they could feel what it was like for people who used the service.

One relative commented, "The regular staff treat my [family member] with dignity and respect. They always have a laugh with her because they know she likes a joke." Another relative commented, "My [family member] is able to make her own decisions and staff really respect this." Some relatives felt agency staff did not have the same knowledge of people so did not treat people in an individualised way. However the vacant posts were being filled, so there would be fewer occasions in future when agency staff were required.

There was a calm, positive atmosphere throughout our visit and we saw that people's requests for assistance were answered promptly. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. Staff were respectful when talking with people calling them by their preferred names. We observed staff knocking on doors and waiting before entering, ensuring people's privacy was respected.

People were asked what they wanted to do and staff listened. We saw staff explaining what they were doing, for example in relation to medicines. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

Staff in all roles were engaged with people as they carried out their jobs in the home including catering and housekeeping staff. A member of housekeeping staff told us, "This is people's home and we try to make it as homely as possible. It's lovely to hear when relatives say it smells lovely and clean."

People told us they were involved in decisions about their care, if they wanted to be. Some people would not be able to be involved due to their limited capacity, but care records showed they were encouraged to make choices about their daily routines. Most of the people who lived here had family members to support them with any significant decisions. Where people did not have family members there was a record within their care plan about the external support they would need for any best interest decisions. There was information in the home for people about independent advocacy services. Staff confirmed that anyone without family support would be assisted to access an advocate to assist them in decisions.

Good

Is the service caring?

People's individual preferences were valued and they were encouraged to make their own daily choices for example what time to get up and how to spend their day. In discussions the catering staff knew people's likes and dislikes as well as any dietary needs. Every day the chef asked at least two people what they thought of the meal.

The chef also joined residents' meetings to ask if anyone had any suggestions for the menus. The chef commented that people at this home preferred traditional and local dishes. They had tried introducing pasta dishes but people did not want these and their views were respected.

Good

Is the service responsive?

Our findings

People and their relatives felt the regular staff were knowledgeable about each person's individual preferences and needs. They felt people received a personalised service. A relative commented, "Staff update me as soon as I come into the home on what has been happening." Care workers commented, "We spend time with people and we know them well and all their little quirks" and "it's very person centred, we have spent a lot of time with each resident finding out about them such as their history and their likes".

A health care professional told us, "It's always the same consistent staff and they know everyone's needs very well. They know their likes very well and they interact well with each person."

People's needs were assessed before they moved into the home and this was recorded. This made sure staff had the skills to meet people's needs and that the home had the necessary equipment to ensure their safety and comfort. Care plans were developed detailing the support each person needed, for example with mobility, continence and specific health needs. The care plan provided guidance for staff so that they could meet people's individual needs in a consistent way.

The care plans we viewed were up-to-date and had been written within the last year. Care plans were reviewed monthly or more frequently if people's needs were changing. Staff told us they were responsible for updating designated people's care plans and we saw that care plans had been reviewed. People and their relatives had been involved in the care plans when they had been re-written, and the care plan documentation was signed by the person or family member. This meant that people were consulted about their care. Records confirmed that people's care plans were reviewed on an annual basis with the person, relatives and other professionals involved in their care.

Each person's care plan contained a social profile (My journal and My preferences), where the information had been collected with the person and their family and gave details about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle. This was important information especially for when a person may no longer be able to tell staff about their preferences.

Care plans were person-centred and focused on what was important to the person. We found that

care records reflected personal preferences and wishes, an example included 'while in bed

[the person] likes their radio on, they have been making facial expressions and smiling to acknowledge conversation'. The individualised approach to people's needs meant staff provided flexible and responsive care, recognising that people living with communication needs could still live a happy and active life.

People said there was a good range of activities and interests at the home for them to take part in if they wished. A visitor told us, "They seem to have lots going on – there are always loads of activities." There were lots of posters in the corridors about the many activities and social events that were planned, including coffee mornings, supper parties and Halloween and Christmas events. There were also photographs of many of the recent activities and social events that had taken place. These included pet therapy with a miniature pony, and people told us enthusiastically about how it had come up to the first floor in the lift.

The provider employed two activities co-ordinators who were dedicated and energetic in their role. Care staff also supported the activities and events for people. One staff member often brought in a small dog to the dementia unit on the first floor and people were clearly enjoying petting it and taking it for walks along the corridor. During this unannounced inspection there were a number of group sessions taking place, such as quizzes and music, as well as one-to-one activities such as nail care and a foot spa. People confirmed outings were arranged and the home shared a bus with another home.

People or their relatives received an information pack about The Laurels. This included clear information about what they could expect from the service and how to make a complaint if they were not happy. The complaints procedure was also displayed in the reception area for visitors.

Some relatives told us they would be happy to raise any verbal comments with the registered manager or other staff. They were confident that these would be acted upon. One relative told us their complaints had been acted on whenever they were raised, although improvements were not always made immediately.

Good

Is the service responsive?

The registered manager kept a log of complaints and these were analysed for any emerging trends. Complaints were also logged on the provider's computerised reporting system (called datix) so that senior managers were aware of these. There had been nine comments or complaints made over the past year. There were records of how these had been investigated, the action taken and the outcome for the complainant. It was clear from records that actions were taken to improve the service.

Good

Is the service well-led?

Our findings

People and their relatives told us they talked with the staff and the registered manager frequently and had opportunities to comment on how it was run. Visitors described this as a "well run" home.

The healthcare professionals we spoke with commented that the service was "effective and well managed".

The home had a registered manager who had been in this post at the home for three years. The registered manager carried out a daily 'walkabout' to check the service. Staff felt the home was well managed although some said they would prefer if the registered manager had more time to spend with people and staff. For example one staff member said, "It's up to seniors to lead the team. The manager is fine as a manager and they've given me the opportunity to experience everything in the home, they've been good that way. I would like them to be on the floor more."

People had various opportunities to give their views and suggestions about the service. The provider had introduced a new 'quality of life' feedback system in its services. This meant people, relatives and other visitors could leave their comments about the home at any time on an easy-to –use iPad computer that was sited in the entrance hallway. People could also request the iPad to be brought to them so they could input their comments at any time. The comments would be 'live' and any significant comments would be emailed immediately to the registered manager for action and this would be recorded on the system.

We saw that the most recent analysis of people's views had been very favourable. At the time of this inspection seven people had completed the on-line questionnaire. Their responses scored 94.8% satisfaction with the service. Also, 20 relatives had completed the survey and scored 95.9% satisfaction.

Resident/relatives' meetings were held every two months and the minutes of the September meeting were on the noticeboard for everyone to read. The activities staff and the catering staff attended these meetings to take feedback and discuss suggestions.

People, relatives and other visitors told us the atmosphere in the home was "welcoming and friendly" and the ethos amongst staff was caring. One activity staff member had recently received a Recognition of Care and Kindness award from the provider after being nominated by relatives. Staff said they felt "very supported" in their role by their immediate supervisors (such as seniors or nurses). Staff told us they enjoyed their jobs and valued their roles in the home. For example, one care worker commented, "I love my job and I love the residents." Another staff commented, "I'm proud of the relationship I have with residents – it's so rewarding."

The staff we spoke with felt there was good communication between all the staff roles. For example, housekeeping staff said they always discussed with care staff when was a good time to access someone's bedrooms for a "full clean", and care staff and catering staff communicated about people's nutritional needs.

There were opportunities for staff to discuss the running of the home at staff meetings and to receive updates about the organisation. There were also heads of department meetings for the registered manager and senior staff members. The registered manager held group supervision meetings to discuss expected practices and the outcomes of their daily walkabout checks.

Some staff took on additional responsibilities as 'champions' in various areas of safety or care, for example infection control, dementia care and fire safety. These lead roles helped to develop staff's knowledge of current best practices and they then monitored their colleagues to make sure all staff were meeting the latest guidelines. For example, observations of staff when using hygiene techniques.

The registered manager and staff carried out a number of regular audits of the service, including care records, premises safety and infection control checks. Many of the checks were now recorded on a new quality tool that involved inputting the information onto an iPad. This computer-based system then analysed the results and identified any actions for improvement. Senior managers of the organisation had access to the results as part of the provider's monitoring of the quality and safety of the service.

The service was also audited by external professionals such as commissioners. In January 2015 the home had scored

Good

Is the service well-led?

78% on a joint audit carried out by commissioners of the local authority and clinical commissioning group (CCG). The staff were working to an action plan to improve this further.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who used the service were not protected against the risks associated with inadequate medicines management.** Regulation 12(2)(f)(g)