R&N Partners

Oakdene Nursing Home

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 inspection took place on 6 September 2016 and was unannounced. This is the first rating inspection of this service.

Oakdene Nursing Home is registered to provide accommodation for up to 37 older people some of whom are living with dementia or have needs associated with mental health. People may have a physical disability and/or a sensory impairment. There were 32 people living at the service when we inspected and the registered manager told us that this would be the maximum they would admit given recent changes to the layout of rooms. An application to the Care Quality Commission to reduce the maximum number of people the service could accommodate was pending. The service had several communal areas including a garden room. It had a lift, and was fully accessible to wheelchairs. It had specialist equipment to assist people with mobility problems and was close to local transport links.

The service had a registered manager. 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.

Medicines were safely handled and risks were well assessed to protect people.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the service. The registered provider had sufficient suitable staff to care for people and staff were safely recruited. Monitoring checks for the environments were carried out and the registered manager told us about how they managed environmental risks. People were protected by the infection control procedures in the service.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date across a range of relevant areas.

Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and they understood the principles of the MCA and DoLs. People were protected around their mental capacity.

People's nutrition and hydration needs were met. People enjoyed the meals. Specialist advice around people's health care was sought and followed.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with dignity and respect. Staff had knowledge and understanding of people's needs and worked together well as a team. Care plans provided detailed information about people's individual needs and preferences. Records and observations provided evidence that people were treated in a way which

encouraged them to feel valued and cared about.

People were supported to engage in daily activities they enjoyed and which were in line with their preferences and interests. Staff were responsive to people's wishes and understood people's personal histories and social networks so that they could support them in the way they preferred. Care plans were kept up to date when needs changed, and people were given opportunities to take part in drawing up their care plans, their reviews and to give their views which were acted upon.

People told us their complaints were responded to and the results of complaint investigations were clearly recorded. Everyone we spoke with told us that if they had concerns they were addressed by the registered manager who responded quickly.

The registered provider had an effective quality assurance system in place. Oakdene Nursing Home was well managed and staff were well supported in their role. The registered manager had a clear understanding of their role. They consulted appropriately with people who lived at the service, people who were important to them, staff and health care professionals, in order to identify required improvements and put these in place. Records around good governance were clear and accurate and led to planned improvements.

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's risks in relation to the home environment and their personal care and treatment were assessed and acted upon.

People were protected from the risks of acquiring infection because the service had infection control policies and procedures and staff acted on these.

People were protected by having sufficient staff who were safely recruited and had the skills and experience to offer appropriate care.

People were protected by the way the service handled medicines.

Is the service effective?

Good

The service was effective.

People told us that they were well cared for and that staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide good care.

The service met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA).

Is the service caring?

Good

The service was caring.

Staff were skilled in clear communication and the development of respectful, caring relationships with people.

Staff involved people in decisions.

Staff had respect for people's privacy and dignity.

People were cared for with compassion when they reached the end of their lives.

Is the service responsive?

Good

The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests which supported staff to offer person centred care.

People were supported to live their lives in the way they chose.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place. Leadership was visible and there was a quality assurance system in place so that the registered manager could monitor the service and plan improvements.

Communication between management and staff was regular and informative.

The culture was supportive of people who lived at the home and of staff. People were consulted about their views and their wishes were acted upon.

Oakdene Nursing 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 registered 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 6 September 2016 and was carried out by two adult social care inspectors. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. Before the inspection, we received a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also gathered the information we needed during the inspection.

We 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

During the inspection visit we spoke with six people who lived at the service, four visitors, five members of care staff including one nurse, the registered manager and deputy manager. During the inspection we spoke with two health and social care professionals and a visiting person who was carrying out activities.

We looked at all areas of the service, including people's bedrooms, when they were able to give their permission. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at five care records and associated documentation. We looked at records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for four members of staff. We also observed the lunchtime experience and interactions between staff and people living at the service.

Good

Is the service safe?

Our findings

People told us that they felt safe at Oakdene Nursing Home. One person told us, "I am looked after safely here." Another person said, "They are good when they move me. I feel safe then." A visitor told us, "I feel [they] are safe and really well cared for here." Another visitor said, "Yes I can go home feeling sure they are safe." A health care professional told us, "There are plenty of care staff on duty, they never seem short of staff." Another professional said, "They assess risks well and have plans in place to make sure people are protected."

We saw there were safeguarding policies and procedures in place. We saw records to confirm staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the service procedure was in relation to safeguarding.

The registered manager had kept CQC informed about safeguarding incidents which had taken place in the service. Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively.

We asked the registered manager how they decided on staffing levels. They told us they calculated this using the numbers and dependency levels of the people living at the service at any time, though they did not use a dependency tool. Staff told us and we observed, that there were sufficient staff on duty to care for people safely with a consideration of skill mix and experience. Most staff worked twelve hour shifts with a fifteen minute handover time to ensure that important information about people's care was shared appropriately. Six care staff were on duty each day time and three were on duty each night. All shifts included a nurse. This was for thirty two people. The registered manager told us that this allowed staff time to care for everyone without rushing and to give extra support to those people who were feeling unwell. Ancillary staff were also employed, such as cooks, maintenance and domestic staff.

Staff confirmed that they had time for handover between shifts so that important information about people's care could be shared. One member of staff told us, "We have good handover and staff are conscientious about passing on important information."

We looked at the recruitment records for four staff which showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) for each member of staff and that two references were obtained before staff began work. DBS checks assist employers in making safer recruitment decisions by checking that prospective care workers are not barred from working with certain groups of people. This meant that the service had taken steps to reduce the risk of employing unsuitable staff.

Care plans identified a person's level of risk and records showed that these were regularly updated to reflect people's changing needs. When they were able to do so, people told us that each area of risk had been

discussed and agreed with them and we saw records which confirmed this. Risk assessments were proportionate and included information for staff on how to reduce identified risks. We did note that some risk assessments focused on preventing harm without fully exploring how people's freedom and independence could be promoted. However, when we spoke with people and with staff they told us that they did focus on promoting independence when they were caring for people and were able to give us examples, such as supporting people to access the community. Staff told us that their approach to risk was responsive to people's changing needs and mental capacity. They told us that the service had an open and positive approach towards managing risk and that management supported and encouraged them to challenge any practice they considered unsafe.

Most accidents and incidents were recorded and the registered manager explained that they analysed these for trends so that the risk of further incidents was minimised. However, some accidents were recorded on body maps but there was no corresponding incident form. This meant that the registered manager may not have all the information they needed to analyse trends and fully promote people's safety.

We spoke with the registered manager about their plans to ensure the service was safe. They had written risk assessments to identify a number of known risks in the building which directed staff to what systems and checks they should have in place to ensure people's safety. The registered manager had a list of what they would regularly check, which included audits to the building and grounds. Records confirmed that regular checks took place. We noted some areas of the service required upgrading, for example some bathrooms had cracked tiles and some equipment had areas of rust. The registered manager told us they had a plan to address these areas. The environment supported safe movement around the building and there were no obstructions.

The service had a fire risk assessment in place and all fire fighting equipment was regularly serviced to ensure it remained safe for use. Each person had a personal emergency evacuation plan (PEEP) which was available on the floor where the person's room was located.

We noted that keys were hung near a door which contained cleaning chemicals and the laundry room. Although the keys were located at a height, they may have been accessible to some people who lived at the service. Following the inspection, the registered manager sent us additional evidence that there had been a risk assessment in place to address this and that they had assessed the risk as low due to the height of the key storage and an assessment of the risk this posed to the individuals who used the service. To eliminate the risk, following our inspection, the registered manager had removed the keys and stored them away from the room containing hazardous substances.

The service handled medicines safely. Solid medicines were dispensed using a monitored dosing system (MDS). MAR charts had a photograph of each person on every individual record. This reduced the risk of medicine administration error.

Those medicines which were not stored in the MDS and were provided in boxes or bottles were stored in named individual sections of the medicine storage trolleys to reduce the risk of administration errors. All medicines stored in this way were dated on opening and a running stock balance of tablets and fluids was kept so that stocks could be accurately monitored. No currently prescribed medicines required fridge storage, but the registered manager showed us that they were prepared for this should someone be prescribed medicines which needed to be stored in this way.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, (CDs) which are medicines that require extra checks and special storage arrangements because of their

potential for misuse. This meant that people were protected around the management of CDs.

The service had a safe system for returning unused medicines and for the disposal of sharps.

We checked the stocks of some boxed medicines against the MAR charts and these were accurate. We also checked a sample of the MDS blister pack medicines against the MAR charts. These were also accurately recorded with no gaps. We observed part of a medicines round. Medicines were administered safely and signed for immediately following administration. The member of staff we spoke with was knowledgeable about people's medicines and why certain medicines were necessary. Nurses with responsibility for administering medicines had received training to ensure they did this safely.

The service had a policy and procedure around medicines which took into account how to safely handle homely remedies, however there was no policy on the use of as required (PRN) medicines to ensure these were safely handled. The registered manager told us they would develop this area of the policy. The policy included the requirements of the Mental Capacity Act (MCA) (2005). Nobody living at the service self-administered medicines, however the registered manager had a policy and procedure should this become relevant in the future and told us how they would risk assess each individual to ensure their safety.

The registered manager told us that GPs regularly visited the service to review the medicines prescribed to ensure these remained appropriate for people's medical needs.

The medicine handling systems in place meant the registered provider had taken steps to ensure that people were protected around the way they received their medicines.

We observed that staff wore protective aprons when offering personal care and dealing with meals which is good practice and in line with infection prevention and control measures. Staff told us that they had received training in the control of infection during their induction and had received regular updates. They correctly described how to minimise the risk of infection. Staff understood the importance of using aprons and gloves and told us that they washed their hands frequently and always between offering care to people. The service had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. Sanitising gels were available around the service. Bathrooms, toilets and people's individual rooms had wall mounted soap dispensers and paper towels in line with current best practice guidelines. The laundry room had a suitable washing machine and dryer. Dirty and clean laundry were kept separate to minimise the risk of cross infection.

Good

Is the service effective?

Our findings

People told us that the service supported them with their health care and that they enjoyed the meals. One person told us, "The meals are really good, they often make our favourites." Another person said, "They seem to be feeding us all the time. They do lovely morning coffee and cakes in the afternoon." One person told us, "They are nice staff and I like the food." A visitor said, "My relative has lost weight due to an infection and the staff are always encouraging them to eat more and often." Another family member told us how their relative moved in and needed to put weight on, they described how this had been successful and how their relative now enjoyed their food.
A family member told us that when their relative was ill recently staff were, "Good at communicating and helpful, they always kept in touch."

Each member of staff had an induction to the service. Staff confirmed that they had received induction before they began their mandatory training. During this time they developed a good understanding of each individual's care needs and the philosophy of the service. Staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met. For example, one member of staff accurately told us about the care a person required including how they should be supported with their eating and drinking.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone and only did so when they were confident. This was to make sure they understood people's individual needs and how risks were managed.

Staff received a range of training relevant to their role including specially sourced training in areas of care that were specific to the needs of people at the service. The registered manager told us about the training they considered mandatory in the PIR. Staff told us about other additional clinical training such as diabetes care, dementia care, pressure ulcer prevention, tissue viability and palliative care. Records confirmed this training took place. Training was delivered in a variety of ways according to what was most appropriate. This included e- learning and externally provided face to face training.

A staff member who had recently started working at the service told us, "As part of my first shift I did an induction to tell me about the basics and I shadowed staff for the first two days and read some care plans. I am now happy with the routine." They went on to say they felt comfortable coming into work because the team made them feel supported.

One staff member told us they had received dementia training and they had learnt to 'take time to listen' which was important to people they supported living with dementia.

Staff, including nurses told us that they received regular supervision and appraisal. Nurses told us that they received clinical supervision and support through the management of the home. We saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and to offer the care people needed. One staff member told us, "My appraisal is booked for today. We have supervision as

well where they ask if we have concerns and feedback [their views about my performance] to me, I find them supportive." Another staff member told us, "My appraisal was useful, we reflected on my practice, they asked if I needed any help."

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 process 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.

People's plans of care showed that the principles of the Mental Capacity Act 2005 (MCA) Code of Practice had been used when assessing people's ability to make decisions. People's need for advocacy involvement was assessed and recorded. The service had a policy and procedure on the MCA and DoLS to protect people. Ten people had been referred and assessed as being deprived of their liberty by professionals from the local authority. CQC had been notified of the DoLS in place.

Staff understood the principles of the MCA and DoLS and were able to tell us about the five main principles, for example that they should approach people with an assumption of capacity, and they should support people to make their own decisions. A staff member explained the principles of the MCA to us as, "Being caring and putting the residents needs first, understanding that people can make unwise decisions and making sure we fulfil all their needs, talk through everything step by step so people understand."

People told us they were regularly asked for their consent to care. We observed that staff routinely asked for people's consent before giving assistance and waited for a response. Care records also showed that people's consent to care and treatment was sought. Care plans contained instructions on how to look for consent when people were not able to give this verbally, for example, through observing body language or facial expressions. People's choices about their care were recorded for staff to follow. For example in one person plan they would choose each day whether they wished to use a prescribed treatment and staff were to respect their decision.

Decisions which needed to be made in a person's best interests were recorded and evidence was provided that this was carried out with a multidisciplinary team approach as the MCA advises.

The living environment had been organised so that people were supported with their needs for stimulation and activity. We noted signs to support people to navigate around the service and there was an activity room which people knew about and attended regularly.

Care plans contained details of how to meet people's clinical care needs. Examples included pressure care, nutrition and fluids, and how to support people to move safely. Risk assessments were in place around clinical care. The service used the malnutrition universal screening tool (MUST) which is a recognised risk assessment tool to determine whether people are at risk of malnutrition. They had scales which could be used for people who were not in a position to bear their own weight. When these were not suitable, a nurse told us that they used the MUST guidance to measure upper arm circumference. Staff recorded health appointments and staff told us people were supported to attend these.

Health care professionals gave feedback about how the service met people's health needs. One professional told us, "The dementia support for people is good, staff analyse people's behaviour and understand the triggers for people. They are pro-active and have a good understanding of dementia." A visiting professional told us, "I am very happy, this is one of the higher rated homes from my workplace, we have never had cause to complain. People have varying needs and they cope well, the staff always have the information we need. We have good communication with the service."

One health care professional wrote to us to tell us the registered manager attended a Social Care Commitment workshop earlier in the year and had accessed training made available to them. They also confirmed that the registered manager had signed up to "React to Red", a pressure care workshop. We noted that there were posters around the home reminding staff to be vigilant about areas of redness on people's skin and staff told us they had received training cascaded through the registered manager on how important it was to treat areas of redness quickly to prevent damage to skin integrity.

We saw that the service had links with specialists, for example the diabetic care nurse, tissue viability nurse and the speech and language therapy team (SALT). Advice from these specialists was written into care plans and daily notes confirmed that the advice was being followed. This advice helped staff to offer appropriate and individualised care.

Food, fluid and turning/ monitoring charts were in place to protect people where necessary. Those we checked were accurately completed with no gaps and reflected the guidance set down in the care plan and risk assessments. This ensured that the registered manager could monitor whether people were receiving appropriate food and drink for their needs.

The service had been awarded a level 5 food hygiene rating by the local council which meant that the level of food hygiene had been assessed as very good.

We observed lunchtime and saw the tables were laid with condiments and fresh flowers. One person told us they really appreciated the fresh flowers. There was a choice of two main meals on the menu. We saw the staff team worked together to provide a calm and personalised service for people. Alternatives were offered and supplied where people chose this. For example one person opted for banana instead of the hot meal.

Staff offered one to one support for people where they needed this in a respectful way. People who required adapted diets were well catered for and we observed people enjoying their food. One person who required additional support to understand it was lunchtime was dealt with patiently by the team and eventually the person did eat their meal with one to one assistance.

Care plans contained information about people's food likes and dislikes. Those people we spoke with told us their preferences around food were respected. Allergies in relation to food or drink were also recorded. Specific diets to take account of medical conditions such as diabetes were recorded, and any fortified or prescribed supplements in use. This meant that people's needs in relation to food and drink were assessed and provided for.

Good

Is the service caring?

Our findings

One person told us "I can get up when I want and go to bed." And, "I get up when I want and I press my buzzer and wait for staff." A visitor told us "My relative is always clean and presentable and really well looked after." Another family member said, "Everyone is so friendly, the quality of care is amazing; people get the right things at the right time." Another person said, "This place always has lovely flowers and the birthday cakes they are lovely and we have candles. It is good how they do it for people." The person's family member said, "My relative had a 90th birthday and they made a lovely cake." Another person told us "It's alright they take care of me, they are friendly and nice." A visiting professional told us they had observed kind and caring staff in the time they had been visiting the service. They told us, "Staff are brilliant, they have exceptional staff and they always have time for people." Another visiting professional told us "I visit a few places and this is more family orientated and you don't feel out of place. People never seem to want for anything."

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. We saw that staff encouraged people to express their views and listened to their responses.

We saw staff reacted immediately to support a person to maintain their dignity and privacy in a communal area during an incident we observed. Staff responded in a low key way so as not draw attention and they spent time reassuring the person and offering them support. One member of staff explained how they reassured one person who sometimes became distressed by sitting with them and spending time talking and reminiscing.

We spoke with one staff member who told us about a person who could not verbally communicate and how staff had learnt how the person said yes and no or needed something. We saw a communication section in this person's care plan which explained the person's specific way of communicating with people.

Staff told us that they respected people's right to privacy and dignity and spoke using a kind tone of voice, listened to people and were sure to support people discreetly and in a way which made them feel comfortable. Care plans contained instructions for staff on each person's needs in relation to emotional support.

We saw a document and photographs in people's care plans which recorded the person's memories and past life. This was a tool for staff to get to know people and understand them better.

One staff member told us, "The best thing about working here is the level of care people receive and the fact people are given a choice and there is an open culture, people are always busy." A visiting professional told us "The staff are always nice and they know the residents well, they know about their histories and families and this shows they have taken time to get to know people."

A staff member who had just started working in the service told us they had observed people being offered choice and being treat with dignity and respect, they felt this made the service a good place to work. A

visiting professional told us "Staff use respectful language and work with people well to understand people, everyone has individual plans."

The registered manager had organised for people who needed them to have communication aids so that they could make an informed decision about options open to them. This included support to attend sight and hearing tests, and to have dental check-ups. Staff told us they visited people in their own rooms and chatted to them so that they did not feel isolated. We observed that staff did visit people who were being nursed in their rooms in this way.

Some people had Advance Plans in place which were well documented. (Advance Plans record people's preferences when they near the end of their lives). Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place, and where we saw these they were correctly completed and regularly reviewed.

Staff told us about the way people were cared for in their final days. Staff had followed the six steps programme which was offered through the local hospice which emphasised the most compassionate and caring way to offer care when a person reached the end of their life. Staff emphasised the need for close liaison with palliative care professionals, attentive monitoring to ensure people did not suffer pain and how important it was to ensure people had company at their beside. They also spoke about the importance of supporting relatives, the people who lived at the service and each other at that difficult time.

Care plans included details of who should be involved when a person reached the end of their life and who had lasting power of attorney. Care plans also contained an information pack to support people to make plans and for their families to access the appropriate support when a person reached the end of their life.

Good

Is the service responsive?

Our findings

People told us about the ways in which the service was responsive to their needs and preferences. One person told us, "We often bounce a ball as an activity. I won bubble bath as a prize when I did the quiz. There is always something going on." Another person said, "We have activities on Wednesday and Thursdays, hula hoop, quiz night, there is one tonight up in the memories room." A visitor told us, "Christmas last year was fantastic, people went out for meals, the theatre and Christmas dinner, they seem to go the extra mile." Another family member told us "My relative was withdrawn at home and now when I visit they tell me about their day." People told us about how the service responded to their complaints. One person told us "I have a few complaints now and again, [the registered manager] is very good and they sort it out."

We observed staff encouraged people to chat with them and each other, and they listened to what people had to say, responding to their needs. We observed staff supporting people with activities such as an aroma quiz and saw that people enjoyed the experience.

People had identified areas of interest, likes, dislikes and preferences within their care plans. People's life histories were recorded with their permission. Plans contained information such as previous occupations, hobbies, family and friendships, spiritual needs, preferred clothing and ways to spend time. Where people did not have the mental capacity to give a view, efforts had been made to consult with others who were important to them or advocates.

Staff told us that they learned about people through talking with them, reading their history on file, talking with other staff and the nurses and speaking with families. A staff member told us "I would let my loved one live here because people have good interaction, there is lots going on and people are not just left, we sit and talk with people."

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs. Staff could tell us about people's care needs and how these had changed. However, daily activities each person engaged in were not always recorded with details of whether these had been enjoyed. The registered manager told us this was something they would look to improve to support them to plan a responsive service in future.

Each care plan was reviewed monthly. However, where changes had been documented, the main care plan had not been always updated. For example, in one person's care plan review advice from a specialist service was recorded but not written in the main care plan. This could lead to confusion and there was the potential that important details of a person's care may not be delivered. The registered manager told us they would improve this practice so that people's needs were more clearly recorded.

The service employed a member of staff whose responsibility was to provide activities to offer people after consultation with them. Staff told us the activity board in the hallway explained each week's programme of events and in addition staff spend time with people on a one to one basis when there were no planned

activities taking place. For example they told us they would offer nail care, look at magazines or play dominoes with people.

The activities worker showed us the records where they have offered people who did not join group activities, one to one support in their rooms. On the day of our visit this included a visit from the 'patting' therapy dog. We saw the range of activities included keep fit, choirs and outside entertainers.

The activities worker told us they supported people to grow vegetables in the garden. They had organised a trip to an Agatha Christie drama at the theatre in April for people and they were soon to support people to attend a production of 'Brassed Off' at the theatre where a local brass band was due to play.

The service had a 'memories' room where activities took place and from which there was access to the garden. People told us they enjoyed using this room and were able to tell us some of the activities which were offered, such as quizzes and reminiscence. We observed a quiz night during our visit and we saw people enjoying this with their visitors, who also joined in.

One person told us they had a hairdresser appointment each week which was what they preferred. The hairdresser was in the service on the day we visited and we observed the good relationships they had with people. They knew their preferences and engaged in friendly banter with everyone.

People had access to a wi-fi connection and telephone in their own bedrooms. This helped people to keep in touch with their friends and family.

Detail about how a person wanted their support to be delivered was recorded in people's care plans. For example we saw one person liked to have moisturiser on their face and perfume used each day. Also they preferred coffee in the mornings and tea in the afternoon. This meant staff had the information they needed to offer a personalised service.

A person told us they had a bath regularly and, "They have all the gadgets to help you into the bath." Staff said people were offered a choice of bath or shower and their preferences were recorded. One staff told us they supported one person to have a bath everyday as this helped them relax and eased their pain.

One person told us how it was difficult to call for help when they were sitting in the lounge because the buzzer was not near to where they sat. We discussed this with the registered manager who was keen to find a solution to help this person and others where needed. They told us they would find access to a bell for people over the week following our inspection.

Staff were aware of how to respond to people's needs when they displayed anxiety. One staff member told us "One person likes peace and quiet so we support them to move lounges if the area is getting too busy or noisy."

The registered manager told us that the service used a keyworker system and staff confirmed this. Staff told us they were assigned as keyworkers for people. Each month. this role included assessing if any changes were needed to the care plan. Staff consulted people in care plan reviews, but acknowledged it was sometimes difficult to include people's views when they did not communicate verbally. They told us they communicated with families and observed people's body language and facial expressions to judge whether people were comfortable with their care.

People told us they would feel confident telling the staff if they had any concerns and felt that these would

be taken seriously. We saw that the service had a complaints procedure and staff told us this was followed. The people we spoke with told us that they were confident that their concerns would be listened to and dealt with courteously. We saw a record of complaints and the outcomes with timescales to monitor how these were managed. When people made a formal complaint the registered manager told us they informed the person of the results of their investigation and consulted the person to check that they were happy with the outcome.

Good

Is the service well-led?

Our findings

A visitor told us, "[The registered manager] is very good at [their] job I can't fault them. I feel I can talk to staff, and raise issues with the manager if I had any problems." Another visitor said, "Our experience as a family has been terrific. My son and I are very impressed." A person told us, "[The registered manager] is very good and definitely part of what is going on," and another family member said, "Very good service. It is like a hotel and is an excellent home, really accommodating."

The service had a registered manager in place. They were supported in their role by deputy staff, and by the registered provider of the service. The service was family run. The registered manager told us that the management team offered good support to each other and they were encouraged to discuss issues in a positive way.

A member of staff told us, "The manager is open and approachable." A visiting professional told us, "They always make you feel very welcome even when you call unannounced, the manager is very nice."

We saw the registered manager was a visible presence in the home and that they had a warm and friendly relationship with people. Staff told us that the registered manager and office team located themselves at the entrance reception so they could speak with visitors and show them they were accessible and willing to help.

The registered manager held regular resident and visitors meetings. We saw some sample minutes of these meetings which showed that they were used as opportunities to listen to people's views and to pass on information. Staff told us they felt able to raise ideas and concerns in the staff meetings they had. They told us they talked about complaints and training. One staff member told us, "I feel we have got a good team. The manager would pull you up if they needed to." Another staff member told us, "I really like it here and the carers really do care, I have no problem with management." Staff told us that residents requested a change to the menu in the resident's meeting and the menu was changed for them. The registered manager and staff told us that resident's meetings were chaired by the activities worker to ensure people felt able to speak up and raise issue in a supportive environment.

The registered manager carried out a range of audits to ensure that the service provided people with safe and good quality care. These included risk areas such as pressure care, infection control, falls, medicines, accidents, fire, kitchen safety and training. Where shortfalls were identified, an analysis was carried out with actions in place to minimise future risks. Lessons learned and reflections for future learning were recorded for staff discussion in meetings. The registered manager also carried out a daily walk around the building where they identified any issues, and spoke with people and staff. The registered manager told us that this supported them to be more visible around the service and to pick up on things which needed attention.

People and those who were important to them had been surveyed for their views about their care and the registered manager told us that the surveys were analysed and any points for improvement were placed into an action plan.

Staff told us that the manager was open and positive with them, and that they felt supported in their role. They had regular staff meetings which gave them information and guidance to care for the people who lived at the service. Minutes were kept and identified actions were recorded.

People we spoke with told us that the registered manager often stopped for a chat and that they were easy to get along with and helpful.

The registered provider had an up to date service user guide and statement of purpose which gave useful information to people who were planning a move into care. Policies and procedures were regularly updated to reflect any changes in legislation and the care given.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the service to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support. The registered manager and staff consistently reflected the culture, values and ethos of the service, which placed the people at the heart of care.

Most notifications had been sent to the Care Quality Commission by the service as required, however we did see that the lift had been out of order for a time and the registered manager had not notified CQC. They told us they had not realised this was necessary, however they agreed to send such notifications in future and we directed them to CQC website for further guidance. The registered manager also sent notifications to other bodies such as the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous occurrences Regulations (2013) (RIDDOR). This meant that the service provided for external scrutiny of incidents and accidents so that people's wellbeing was protected.