HICA

The Rowans - Care 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 23 March 2017 and was unannounced. At the last comprehensive inspection of the service in August 2015 we rated the home as Requires Improvement due to breaches in Regulation 11: Need for consent, Regulation 15: Safety and suitability of the premises and Regulation 17: Good governance. We rated Safe, Effective, Responsive and Well-led as Requires Improvement, and Caring as Good. An action plan was submitted by the home to tell us how they would improve these areas so they were no longer in breach of regulation.

At this inspection we found that improvements had been made to the premises, although some re-decoration was still outstanding. Care plans recorded people's ability to consent to their care and there were effective quality monitoring systems in place.

The home is registered to provide accommodation and care for up to 53 older people, including people who are living with dementia. On the day of the inspection there were 48 people living at the home, either within the 'residential' or 'dementia' areas of the home. The home is situated in Kirkella, a village in the East Riding of Yorkshire but also close to the city of Kingston upon Hull. The premises are on one level and there is easy access into the premises.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were protected from the risk of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had received training on these topics and understood their responsibilities.

Care plans were a good reflection of people's individual needs and how these should be met by staff.

There were recruitment and selection policies in place and these had been followed to ensure that only people considered suitable to work with vulnerable people had been employed. On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs, although we felt that the deployment of staff to ensure they were always visible could be improved.

Staff told us they received the training they needed to carry out their roles effectively and confirmed that they received induction training when they were new in post. Staff told us that they were well supported by the registered manager.

Senior staff had received appropriate training on the administration of medication. We checked medication systems and saw that medicines were stored, recorded and administered safely.

People who lived at the home told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home and staff, and that staff had a good understanding of people's individual care and support needs.

A variety of activities were provided and people were encouraged to take part. People's family and friends were made welcome at the home.

People told us that they were satisfied with the food provided. We saw that people's nutritional needs had been assessed and individual food and drink requirements were met.

The registered manager was aware of how to use signage, decoration and prompts to assist people in finding their way around the home.

There were systems in place to seek feedback from people who lived at the home, relatives, staff and health and social care professionals. People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been investigated and appropriate action had been taken to make any required improvements.

Quality audits undertaken by the registered manager and senior managers were designed to identify that systems at the home were protecting people's safety and well-being.

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.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

Staff had been recruited following the home's policies and procedures and there were sufficient numbers of staff employed to ensure people received safe and effective support.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Is the service effective?

Good

The service was effective.

Staff completed training that gave them the skills and knowledge required to carry out their roles effectively.

People's nutritional needs were assessed and we saw that meals were prepared to meet people's individual dietary requirements.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. People's physical and mental health care needs had been met.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their support needs and how these should be met by staff. Care provided was centred on the individual person.

Activities were provided and visitors were made welcome at the home.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post. They had submitted notifications as required by legislation.

Staff told us that they were well supported by the registered manager and senior managers within the organisation.

Audits were being carried out to monitor the effectiveness of the service. There were opportunities for people who lived at the home and other people involved in their care to give feedback about the service provided.

The Rowans - 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 checked 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.

The inspection took place on 23 March and was unannounced. The inspection was carried out by one adult social care (ASC) inspector 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.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection and it was returned to us within the required timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

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.

On the day of the inspection we spoke with four people who lived at the home, two visitors, four members of staff, a health care professional, the registered manager and the quality assurance manager. We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

At the last inspection of the service we found that floors were not clean, that some bathrooms and toilets were poorly maintained and that some outdoor areas did not provide safe space for people to spend time in. This was a breach of Regulation 15: Premises and equipment of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements had been made. The bathrooms and toilets we saw were clean and well maintained, carpets in communal areas of the home had been replaced with non-slip flooring and improvements had been made to one of the enclosed courtyards. There was a refurbishment programme in place and, although this had not been completed, good progress had been made. One outdoor area still required refurbishment and the door was locked so people could not gain access. Some areas of the home still required redecoration but the main areas of the home had been redecorated, creating a pleasant environment for people who lived at the home.

People who lived at the home told us they felt safe living at The Rowans. One person said, "The girls are always here. I have a buzzer [to call the staff]." This view was supported by a relative who we spoke with. They told us, "People look out for [name of family member]. No-one can get in or out."

Information to advise staff how people should be assisted to mobilise was included in care plans; this included any equipment and staff support that would be needed to carry out each activity. On the day of the inspection we observed staff using mobility equipment safely to move people. We saw that people had equipment in place and that charts were used to record positional changes carried out by staff, to reduce the risk of them developing pressure sores.

Staff told us that they regularly completed training on safeguarding adults from abuse. This was confirmed in the training records we saw. Staff were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse. Staff told us that they would report any concerns to the registered manager and were certain the issue would be dealt with according to the organisation's policies and procedures. Staff told us they would not hesitate to use the home's whistle blowing policy if they had cause to and that they were confident the information would be kept confidential by the registered manager and the organisation.

We checked the home's safeguarding folder and observed that incidents were recorded appropriately and the local authority safeguarding adult's team had been notified of incidents when this was required. There was also a record of any action taken following safeguarding incidents to reduce risk levels and help prevent the same type of incident reoccurring. Prior to the inspection the safeguarding adult's team told us they had received 21alerts from or about incidents at the home since January 2016. Most of these had not progressed to investigation by the safeguarding team as they told us they felt appropriate action had been taken by the home. We had not received outcomes in respect of the most recent alerts.

We checked the recruitment records for two members of staff and these records evidenced that an

application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with vulnerable adults. Documents that confirmed the staff member's identity had been retained.

Agency staff were used to cover some staff absences. The registered manager obtained a profile of the agency worker to ensure that they had been safely recruited and had completed appropriate training; these were shown to us on the day of the inspection.

During the inspection we saw that there were sufficient numbers of staff on duty to meet people's needs. This included the registered manager, the deputy manager, two team leaders and six care workers. The staff rotas showed there were four staff on duty overnight; one team leader and three care workers, and that these staffing levels had been consistently maintained. People told us that there were sufficient numbers of staff on duty. One person said, "There is always someone about. I've never had to use the call bell" and another told us, "There seems to be a lot about. I used the call button once and staff came quickly."

In addition to care staff, there was an administrator and a maintenance person employed each day, Monday to Friday. A kitchen assistant, two or three domestic staff, a laundry assistant and one or two activities coordinators were on duty each day. This meant that care staff were able to concentrate on supporting the people who lived at the home.

We saw that, although there were sufficient numbers of staff on duty, there was not always a staff presence in communal areas of the home. This was also raised with us by a health care professional, and was acknowledged by the registered manager. They told us they would reconsider staff deployment to ensure that all areas of the home were supervised at all times.

If risks were identified when care needs assessments had been carried out, risk assessments had been completed to record the level of risk and how the risk could be minimised. We saw risk assessments for areas such as skin integrity, mobilising, use of wheelchairs and bed rails, falls and choking. Risk assessments were reviewed on a regular basis to ensure they remained relevant and up to date.

Care plans recorded possible behaviours that might challenge the service. We observed that if people became anxious or distressed, staff were skilled in distracting and calming them. Staff told us that they never used physical restraint in these situations.

There was a business continuity plan in place that included advice for staff on how to deal with emergency situations such as power failure, a pandemic, damage to the building, utilities failure and staff not being able to get to work. In addition to this, each person had a personal emergency evacuation plan (PEEP) in place. PEEPs record the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many staff would be required to assist.

There was a comprehensive medication policy in place and we observed that medicines were appropriately ordered, received, recorded, administered and returned when not used.

Medicines were supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. Medicines were stored securely in two medicines trolleys; one for each area of the home. These were stored in locked medication cupboards. Controlled drugs (CDs) were also stored securely. CDs are medicines that require specific storage

and recording arrangements. We checked a sample of entries in the CD book and the corresponding medicine and saw that the records and medicine held in the cabinet balanced.

We saw that the temperature of the medicine fridge and the medicine room were checked and recorded to ensure that medicines were stored at the correct temperature. Medicines that needed to be returned to the pharmacy were stored securely and recorded in a returns book. In most instances there was an audit trail to ensure that medicines prescribed by the person's GP were the same as the medicines provided by the pharmacy. We discussed that it would be good practice to photocopy any prescriptions issued 'mid cycle' so staff could check that the medicines provided by the pharmacy were the same as those prescribed by the GP.

We looked at MAR charts and found that they were clear, complete and accurate. There was a laminated sheet for each person who had a MAR chart in place and this included the person's photograph, their date of birth and the name of their GP. This helped new staff to identify people when they administered medicines. Some new care plans included information about how the person preferred to take their medication and the registered manager told us this would be rolled out to all care plans. Best interest decisions had been made for some people in respect of 'as and when required' (PRN) medication when they lacked capacity to make this decision themselves.

Staff told us that only the registered manager, the deputy manager and team leaders were responsible for the administration of medicines, although care workers administered creams under supervision. Staff previously had competency checks each year but the registered manager told us this had recently been increased to six-monthly to make these checks more robust.

Medicines were audited each month; the March 2017 audit had identified three medication errors and alerts had been submitted to the safeguarding adult's team. We were informed by the safeguarding adult's team following the inspection that no further action had been taken by them, as they felt appropriate action to reduce the risk of the errors occurring again had been taken by the home.

We checked the accident and incident records in place at the home. We saw that these were recorded appropriately and that a 72 hour observation form was used to monitor people after any accidents or incidents to assist staff to monitor their recovery. The registered manager completed a monthly analysis of accidents and incidents to help them identify any patterns that were emerging or any further action that needed to be taken in respect of a person's increased care needs.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the fire alarm system, fire extinguishers, portable electrical appliances, gas safety, the electrical installation and hoists and slings. There was a fire risk assessment in place.

People who lived at the home and relatives told us the home was maintained in a clean and hygienic condition. The registered manager carried out a regular 'walk around' to check on cleanliness and hygiene. These checks were recorded and there was a record of any action taken to improve the environment. The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

Is the service effective?

Our findings

At the last inspection of the service we were concerned that some people had not consented to their care, and when they were not able to consent, best interest meetings had not always been held. This was a breach of Regulation 11: Need for consent of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we saw that a person's capacity to make decisions and consent to their care was recorded in their care plan, and any best interest decisions made on a person's behalf were also recorded. These records showed that the MCA principles had been followed. When people had capacity they had been asked to sign a form declaring whether or not they wished their family to be involved in decisions about their care.

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 MCA 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. We saw that some applications had been submitted to the local authority for consideration and had been approved. There was a record of when the DoLS were due for renewal.

The training record showed that staff had completed training on the MCA, and staff who we spoke with understood the principles of this legislation. People told us that staff asked for consent. One person said, "I am always asked. I would really recommend it here – it's really caring." A member of staff said, "We ask for permission." Staff told us that they assisted people to made day to day decisions such as what to wear, what to eat and what time to go to bed.

Staff told us they had completed a thorough induction programme and this was confirmed in the staff records we reviewed. Induction training was organised by the head office; new staff carried out a week of training followed by shadowing experienced staff. We advised that the topics covered in induction and details of shadowing shifts should be recorded in staff files for future reference.

Staff told us they were happy with the training they received. Training records showed that all staff (including ancillary staff) completed training on safeguarding adults from abuse, back care, fire safety, first aid, infection control, food hygiene, health and safety, data protection, dementia and the MCA. In addition to this, care staff completed training on care of the dying, pressure area care, more advanced dementia training and the use of the malnutrition universal screening tool (MUST). The MUST is a tool used to assess people's nutritional well-being.

National Vocational Qualifications (NVQs) or equivalent at Level 2 or 3 were not recorded on the training

record. However, we were told that some staff had achieved these awards. If new employees already had a NVQ or equivalent, they had to complete the home's induction programme but were not required to complete the Care Certificate. People new to the caring profession were expected to complete the Care Certificate. This ensured that new staff received a standardised induction in line with national standards.

Staff told us that they had supervision meetings with a manager or team leader and that they felt they were well supported. Comments included, "I have regular supervision meetings and monthly senior meetings." Records displayed in the manager's office showed that staff had a supervision meeting every two months, some of which were group supervision meetings, plus an annual appraisal.

People told us that they could see their GP and other health care professionals whenever they needed to. One person told us, "I had a chest infection and the doctor prescribed antibiotics. I have seen a dentist and my daughter does my nails." Any contact with health and social care professionals was recorded in people's care plans. Relatives told us they were kept informed about their family member's health and welfare, such as visits from their GP.

People had hospital passports in place. These are documents that people can take with them to hospital appointments and admissions when they are not able to communicate information about their care and support needs to hospital staff. They provide hospital staff with information about the person to enable them to meet their needs.

People told us that they were satisfied with the meals provided at the home. One person told us, "If I don't like something they fetch me something else. I have enough to drink; I have Ovaltine at night" and another said, "[The food] is good. I'm asked what I want an hour before dinner time. I get enough, it's hot and I get enough drinks." Staff told us that people's dietary needs were recorded in their care plan, on food and fluid charts and in the food diary, and there was a list in the kitchen that recorded people's special diets as well as their likes and dislikes. The meals, including special diets, were provided by an outside caterer and heated by staff

We did not see a menu board displaying the day's menu. Staff told us that they informed people about the choices on the menu about an hour before lunch. Some people had difficulty making a choice and both meal choices were shown to them at lunchtime to help them make a decision. We observed the serving of lunch in the dining room. Tables were set with tablecloths, napkins, cutlery and glasses. The meal looked hot and appetising and people were offered a choice of drinks and desserts following the main meal. Some people were able to eat independently, some people had specialised crockery and cutlery so they could eat without support and other people were assisted by staff.

Referrals had been made to dieticians or the speech and language therapy (SALT) team when concerns about nutrition or swallowing / choking had been identified following completion of the MUST or other assessments. Advice from these health care professionals had been incorporated into people's care plans and we observed that this advice had been followed.

The premises were on one level, which was considered to be a positive feature of the home by relatives. We saw that there was signage to assist people to find toilets, bathrooms and shower rooms and that bedroom doors were clearly numbered, with an additional sign to indicate that the room was a bedroom. Bedroom doors were also painted in different colours and some had pictures beside them to help people identify their own bedroom. We discussed that communal areas of the home would benefit from additional signage. Flooring and walls in corridors were plain, with contrasting handrails; research shows that people with cognitive difficulties find plain flooring and decoration less distracting and confusing. These prompts helped

people who were living with dementia to orientate themselves within the home.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff really cared about them. Their comments included, "Very caring, lovely. There isn't one who isn't caring", "[Staff] are polite and always help me" and "They treat me right." We asked relatives if they thought staff really cared about the people who lived at the home and they told us, "Yes, you can see by the way they are with [Name of family member]" and "Yes, they are all nice people."

We saw positive interactions throughout the day between people who lived at the home and staff. We saw that people were comfortable in the presence of staff, and that staff were kind, attentive and patient.

The topics of privacy, dignity, person-centred care, equality and diversity, respect and values were included in the staff induction programme. It was clear that people were treated as individuals and that staff knew people's personality traits and likes / dislikes. We saw that people were dressed and groomed in their chosen style, and that women wore jewellery and makeup if this was their choice.

Care plans recorded people's preferred name and we saw that these were used by staff. We saw that staff respected people's privacy by knocking on doors and asking if they could enter the room. One person who lived at the home told us, "I feel comfortable when staff shower me. I've never felt embarrassed. And they knock on my door." Other people said, "They knock on the room door before coming in" and "They are always good with me. I feel comfy when they are bathing me." Staff described to us how they protected people's modesty by covering them appropriately during assistance with personal care.

People told us that staff shared information with them appropriately. Comments included, "There is always someone to chat with. We have a natter when they take me for a cigarette" and "When they bring me anything, I understand them."

Staff told us they promoted people's independence. Comments included, "We encourage people to make their own decisions, we let them take risks" and "We give them choices." This was supported by relatives who we spoke with. One relative told us, "They are encouraged to do things themselves. They are quite independent." People's bedrooms were personalised with photographs and ornaments from their previous home, to help them feel at home.

Information about advocacy was available for people who lived at the home and their relatives. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. Some people were supported by an Independent Mental Capacity Advocate (IMCA). IMCAs provide support for people who lack the capacity to make their own decisions and have no-one else to represent them.

The need to ensure confidentiality of information was included in the staff induction training programme. We saw that information about people who lived at the home and staff was stored securely, and passwords were required before staff could access information stored electronically.

People's wishes for care at the end of their life were recorded in their care plans, when they had been able or willing to share this information with staff. This showed that people had been consulted about their future care needs.

Good

Is the service responsive?

Our findings

The care records we saw included pre-admission assessments, risk assessments and care plans. Topics covered in care plans included communication, lifestyle, skin integrity, eating and drinking, pain, personal hygiene, mental health and cognition and medication. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care, a falls assessment and the MUST tool. When risks had been identified, there were appropriate assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk.

We saw that care plans recorded information in a one-page profile, including the person's care preferences, their dietary preferences, how they communicated, their health needs and things that were important to them. There was also a set of 'getting to know you' questions that recorded details of people's family and friends, work life, hobbies, holidays, pets, likes / dislikes, favourite music and personality traits that would help staff to become familiar with the person's individual care needs. We asked staff how they got to know about people's individual needs and they told us they read care plans and spoke with relatives. One member of staff said, "We ask residents and send a copy to relatives for input. We find time to have a natter, have 1:1's and allocate key workers."

People were not always able to verbally express when they were in pain. In these instances, care plans recorded the signs staff should look out for that indicated the person was in pain, such as flinching, limping or rubbing the affected area.

Care plans were reviewed each month and updated as required. We saw that care plans included a care plan audit form that recorded any shortfalls and when these had been actioned. We found some minor anomalies in care plans and were told that these would be rectified when the care plan audit was carried out.

Staff told us they had handover meetings at the beginning of each shift. Each person who lived at the home was discussed so that staff on the new shift were aware of everyone's well-being. Staff said these meetings helped them to keep up to date with people's care needs. The handover sheet also included reminders for staff about medicines to 'chase up', completing daily diary sheets and any appointments or escort duties that were required for people who lived at the home.

Both relatives who we spoke with confirmed they felt there was good communication between themselves and staff at the home. One relative said, "I am always consulted. I'm advised if a doctor has been or if they have any appointments. Yes - good communications." We saw that any contact with relatives was recorded in people's care plans. The activities coordinators planned to produce a two monthly newsletter, which would be an additional resource to keep people informed of events at the home.

People told us their relatives were made welcome at the home. One person said, "Yes, even the dog too, and they visit anytime." Staff told us that they supported people to keep in touch with family, friends and the local community. Comments included, "We make visitors welcome and encourage phone calls" and "The

activity coordinators are keen to involve outside people. We have monthly relatives meetings and encourage local church involvement." The activities coordinator told us that a local church held a service at the home each month and had started to provide cinema events; they invited people who lived at The Rowans to take part. People were also included in a monthly dementia activity at the local library. People who lived at the home told us there were activities available if they wanted to take part. One person said, "I've been too poorly but I will join in – I've seen an entertainer" and another told us, "They ask me and sometimes I join in."

We used the Short Observational Framework for Inspection (SOFI) to observe the care and support provided to some of the people who lives at The Rowans and to help us understand their experience of living at the home. We found that staff were attentive and responsive to people's needs. We observed that staff made efforts to engage people in conversation and encouraged people to join in activities.

We saw the weekly activity programme displayed in the home; this included words and pictures to aid people's understanding. Activities included exercise classes, bingo, quizzes, skittles, ballgames, arts and crafts and visiting nearby public houses. The activities coordinator told us they also spent one to one time with people; one person liked to have the newspaper read to them and another person liked staff to help them feed the birds. A hairdresser visited the home every week. Any activities people took part in were recorded in a central record and also in the person's care plan. This helped to provide a holistic record of the person's care provision.

Staff told us that they would recognise if something was wrong with a person even if they could not verbalise this. They said, "We would know if something was wrong, as we know them so well." They said they would complain on the person's behalf if needed.

The complaints policy and procedure was displayed around the home and included in the home's statement of purpose. The complaints log showed that any complaints received had been investigated and there was a record of the outcome. Complaints were being dealt with in line with the home's policy and procedure.

People who lived at the home told us that they had not needed to make a complaint. One person said, "I would tell one of the carers, but I've no complaints." Relatives shared this view. One relative said, "I would see the girl on the desk or the manager, but I have no issues." Staff told us they would deal with any minor complaints themselves but if the complaint was more serious, they would inform the registered manager or deputy manager.

People who lived at the home told us that they were not aware of 'resident' meetings and that they had never completed a satisfaction survey. However, we saw the minutes of a meeting when 11 people who lived at the home had attended and activities had been discussed. We also saw the analysis of a service user survey and noted that most comments were positive, including 'Staff treat me lovely'.

The most recent relative meeting had been arranged for 14 March 2017 but no relatives had attended. As an alternative, the deputy manager spoke to visitors as they arrived at the home to ask them for feedback.

Good

Is the service well-led?

Our findings

At the last inspection of the service we found that quality audits had failed to identity that MCA guidance was not been followed, care plans had not been updated to reflect people's current level of needs, medicines were not stored at the correct temperature, staff supervisions had not taken place and that food and fluid charts were not accurately completed. This was a breach of Regulation 17: Good Governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that quality audits were effective.The registered manager carried out various quality audits to monitor that the service was being operated safely and to meet people's assessed needs. A new care plan audit had been introduced and this had resulted in improvements to the content in care plans. In addition to this, accidents and incidents, medication, the prevention and control of infection and the environment were audited. An IT system called 'SharePoint' was used to record any accidents or incidents, safeguarding concerns and complaints. This information was analysed by the registered manager but also by senior staff at the organisation's headquarters to monitor whether any patterns were emerging or improvements needed to be made. The organisation had a quality improvement plan in place that reflected on service provision over the previous two years, along with pledges and an action plan for the year 2016 – 2017.

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration. They had been registered with CQC since January 2016.

We found the registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. The submission of notifications allows us to check that the correct action has been taken by the registered persons following accidents or incidents.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to their care and support. Most of these were readily available and others we requested to see were forwarded to us immediately after the inspection.

We observed that the registered manager interacted with people who lived at the home throughout the day and that these interactions were positive and friendly. It was clear the registered manager knew the people who lived at the home, and people told us they knew who the registered manager and the deputy manager were. One person told us, "There are two managers and both are okay. They ask if I am okay" and another said, "She is very nice but I can't recall her name."

We asked staff what they felt about the management and leadership at the home and they responded positively. One staff member said, "The team we have is so supportive – phenomenal" and another told us, "Brilliant – the seniors are supportive." One person added, "The area manager is amazing – we have a really good relationship. No issues at all."

A relative told us that they had recently completed a satisfaction survey. We saw the analysis of a relative survey and noted most comments were positive. One relative had stated 'The personal care and attention mum has received has led to a significant improvement in her physical and emotional well-being since she came to the home'. Three health care professionals had also returned a survey and we saw that all responses were positive.

We asked staff to describe the culture of the home. Their comments included, "Our strongest suit is that we are so honest with ourselves", "We are one big family", "It's a lovely place to work" and "People's needs are always respected." The registered manager described the culture as, "We make a difference. We encourage, value and empower the staff. We enjoy putting a smile on people's faces."

There was a list of meetings displayed in the registered manager's office. These showed that separate meetings were held for care workers, senior staff, activities coordinators, maintenance staff, kitchen assistants and domestic / laundry assistants. Care staff told us they attended monthly meetings and that they could ask questions and make suggestions at these meetings. We saw the minutes of a selection of meetings and these showed that staff were informed about the outcome of the compliance visit by the local authority, health and safety issues and training, and that learning from recent incidents was discussed. Staff told us they were able to contribute to these meetings.

Staff had also completed a satisfaction survey. Some staff had commented that there were not enough staff on duty. Because of this feedback, the registered manager had issued them with an additional survey to explore this feedback further. This showed that staff had been listened to.

Staff told us that they learnt from incidents that occurred at the home. They told us, "Any incidents are always discussed and a plan of attack is put in place" and "Any concerns are spoken about openly and we try to make improvements." We also saw information in care plans that evidenced there had been learning following incidents at the home. For example, there was a memo in one person's care plan that had been sent to all team leaders in respect of recording comments from district nurses and liaison with district nurses, and information that needed to be shared with the safeguarding adult's team. This was because concerns had been identified about the person's care that had not been shared or recorded appropriately.