Barchester Healthcare Homes Limited

The Hawthorns

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 9 and 10 May 2016 and was unannounced. This meant the staff and the provider did not know we would be visiting. The home had a registered manager in place. A registered manager is a person who has registered with CQC 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.

The Hawthorns was last inspected by CQC on 3 February 2014 and was compliant with the regulations in force at the time.

The Hawthorns is located in a residential setting in Peterlee in County Durham. It provides accommodation with personal care for up to 98 people within three different categories of care, neurological rehabilitation (34 beds), dementia care (Seaham House, 27 beds) and general nursing (37 beds). On the day of our inspection there were 94 people using the service.

We saw that entry to the premises was controlled by key-pad entry but was generally open during the day. All visitors were required to sign in. This meant the provider had appropriate security measures in place to ensure the safety of the people who used the service.

The home comprised of 98 bedrooms, the majority of which had en-suite bathrooms. Facilities included several lounges and dining rooms, communal bathrooms, shower rooms and toilets, a hairdressing room, sensory room, treatment room, a gym and several communal gardens. The general reception was large and spacious with a comfortable seated area which provided people who used the service and visitors with tea/coffee facilities and a computer with internet access.

People who used the service and their relatives were complimentary about the standard of care at The Hawthorns. We saw staff supporting and helping to maintain people's independence. People were encouraged to care for themselves where possible. Staff treated people with dignity and respect.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. There were sufficient numbers of staff on duty in order to meet the needs of people using the service.

Training records were up to date and staff received supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and was suitably designed for people with dementia type conditions.

The service was working within the principles of the Mental Capacity Act 2005 and any conditions on

authorisations to deprive a person of their liberty were being met.

All the care records we looked at contained evidence of consent.

People were protected against the risks associated with the unsafe use and management of medicines.

People had access to food and drink throughout the day and we saw staff supporting people at meal times when required.

People who used the service had access to a range of activities in the home.

All the care records we looked at showed people's needs were assessed. Care plans and risk assessments were in place when required and daily records were up to date. Care plans were written in a person centred way and regularly reviewed.

We saw staff used a range of assessment tools and kept clear records about how care was to be delivered and people who used the service had access to healthcare services and received ongoing healthcare support.

The registered provider had a complaints policy and procedure in place and complaints were fully investigated.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

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.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Staff had completed training in safeguarding of vulnerable adults and knew the different types of abuse and how to report concerns. Thorough investigations had been carried out in response to safeguarding incidents or allegations.

The provider had procedures in place for managing the maintenance of the premises.

Is the service effective?

Good

The service was effective.

Staff were properly supported to provide care to people who used the service through a range of mandatory and specialised training and supervision and appraisal.

People had access to food and drink throughout the day and we saw staff supporting people when required.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and was suitably designed for people with dementia type conditions.

Is the service caring?

Good

The service was caring.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

The staff knew the care and support needs of people well and took an interest in people and their relatives to provide individual personal care.

People who used the service and their relatives were involved in developing and reviewing care plans and assessments.

Is the service responsive?

Good

The service was responsive.

Care records were person-centred and reflective of people's needs.

People who used the service had access to a range of activities in the home.

The provider had a complaints procedure in place and people told us they knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The provider had a quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff we spoke with told us they felt able to approach the manager and felt safe to report concerns.

The service had policies and procedures in place that took into account guidance and best practice from expert and professional bodies and provided staff with clear instructions.

The Hawthorns

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 10 May 2016 and was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two adult social care inspectors and a specialist adviser in nursing.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. We contacted professionals involved in caring for people who used the service, including commissioners, safeguarding and infection control staff. No concerns were raised by any of these professionals. We also contacted the local Healthwatch and no concerns had been raised with them about the service. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work.

During our inspection we spoke with eight people who used the service, eight relatives and we were also contacted immediately after the inspection by the relative of a person who had once used the service. We spoke with the registered manager, the deputy manager, five nurses, a clinical psychologist, a trainee clinical practitioner, four care staff, an activities co-ordinator, an administrative assistant, a receptionist, a domestic, a maintenance man, a cook and two kitchen assistants.

We looked at the personal care or treatment records of nine people who used the service and observed how people were being cared for. We also looked at the personnel files for seven members of staff.

We reviewed staff training and recruitment records. We also looked at records relating to the management of the service such as audits, surveys and policies.

Before the inspection, the provider completed 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.

Good

Is the service safe?

Our findings

People who used the service and their relatives told us they felt safe, for example, "Yes I feel very safe. I leave my door open", "She's very safe", "No concerns" and "Everything's fine. Yes, she's well looked after".

The Hawthorns comprised of 98 bedrooms. The en-suite bathrooms, communal bathrooms, shower rooms and toilets were clean, suitable for the people who used the service and contained appropriate, wall mounted soap and towel dispensers. Grab rails in toilets and bathrooms were secure. All contained easy to clean flooring and tiles. We saw infection control audits and cleaning schedules were up to date. Staff had completed infection control training and were observed to wash their hands before and after aspects of personal care. Gloves and aprons were readily available to staff and were used as necessary. A relative told us "It's very clean". This meant the provider had taken action to reduce the risk of infection and improve the cleanliness of the home.

We saw that entry to the premises was via a locked, key pad controlled door and all visitors were required to sign in. This meant the provider had appropriate security measures in place to ensure the safety of the people who used the service.

Equipment was in place to meet people's needs including hoists, pressure mattresses, shower chairs, wheelchairs and pressure cushions. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Window restrictors were fitted to the windows of the rooms we looked in and appeared to be in good condition. Call bells were placed near to people's beds or chairs and were responded to in a timely manner.

Hot water temperature checks had been carried out and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014. We looked at the records for portable appliance testing, gas safety and electrical installation. All of these were up to date.

We looked at the registered provider's accident reporting policy and procedures, which provided staff with guidance on the reporting of injuries, diseases and dangerous occurrences and the incident notification requirements of CQC. Accidents and incidents were recorded and the registered manager reviewed the information monthly in order to establish if there were any trends.

We saw a fire emergency plan in the reception area. This included a plan of the building. We saw a fire risk assessment was in place dated July 2015 and regular fire drills were undertaken. We also saw the checks or tests for firefighting equipment, fire alarms and emergency lighting were all up to date.

We saw a copy of the registered provider's business continuity plan dated September 2015. This provided the procedures to be followed in the event of a range of emergencies, alternative evacuation locations and emergency contact details. We looked at the personal emergency evacuation plans (PEEPS) for people. These described the emergency evacuation procedures for each person who used the service. This included

the person's name/room number, impairment or disability and assistive equipment required. This meant the provider had arrangements in place for managing the maintenance of the premises and for keeping people safe.

We saw a copy of the registered provider's safeguarding adult's policy dated September 2013, which provided staff with guidance regarding how to report any allegations of abuse, protect vulnerable adults from abuse and how to address incidents of abuse. We saw that where abuse or potential allegations of abuse had occurred, the registered manager had followed the correct procedure by informing the local authority, contacting relevant healthcare professionals and notifying CQC. Staff had completed training in safeguarding of vulnerable adults. The staff we spoke with knew the different types of abuse and how to report concerns. This meant that people were protected from the risk of abuse.

We discussed staffing levels with the registered manager and looked at staff rotas. The registered manager told us that she was currently in the process of recruiting nurses, including a head of unit for Seaham House, and how the service aimed to enrol more care practitioners who would receive additional training to enable them to perform more complex tasks and undertake care planning to support the nursing team, to alleviate the current nurse recruitment issues. The registered manager told us that the levels of staff provided were based on the dependency needs of residents calculated by a dependency indicated care equation (DICE) and any staff absences were covered by existing home staff or regular agency nurses. We saw there were thirty five members of care staff on a day shift which comprised of eight nurses, one speech and language therapist, one assistant occupational therapist and twenty five care staff and four nurses and thirteen care staff on duty at night. The staff we spoke with told us that staffing was appropriate based on the current client groups and how there was some flexibility to increase hours if necessary. Staff told us, "We can get support from other units if we need it", "We all bounce ideas off each other" and "We all pull together". We observed sufficient numbers of staff on duty.

We looked at the selection and recruitment policy and the recruitment records for seven members of staff. We saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS), formerly Criminal Records Bureau (CRB), checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Each record contained a staff photograph and proof of identity was obtained from each member of staff, including copies of passports, birth certificates, driving licences and marriage certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. The registered manager told us how she planned to involve people who used the service in the interviewing and selection of staff over the next twelve months.

The service had generic risk assessments in place, which contained detailed information on particular hazards and how to manage risks. Examples of these risk assessments included falls, use of bed rails, staffing levels and stress at work. We looked at the disciplinary policy and from the staff files we found the registered manager had disciplined staff in accordance with the policy. This meant the service had arrangements in place to protect people from harm or unsafe care.

We looked at the registered provider's medicines policy dated September 2013 which covered all key areas of safe and effective medicines management. There was also a copy of the British National Formulary 2016, which is a pharmaceutical reference book produced by the British Medical Association and the Royal Pharmaceutical Society of Great Britain, available for staffs reference. Medicines were supplied by a national pharmacy chain. Staff expressed some dissatisfaction with the service, for example, missing items in deliveries and supply difficulties with certain medicines. This issue was being addressed on the second day

of our inspection with a manager from the supplier and nursing leads from the home. There were clear procedures in place regarding the ordering, supply and reconciliation of medicine. Clear guidance was in place to ensure staff were aware of the circumstances to administer "as necessary" medicine. We saw that monthly medicine audits were up to date and included action plans for any identified issues.

We looked at the medicines administration records (MAR) for twenty six people and found there were no omissions. Photo identification for each person was in place and allergies were recorded. Medicine administration was observed to be appropriate. Medicines that were required to be given at specific times, for example before food (Lansoprazole) and once a week (Alendronic Acid) were clearly identified on the MARs and had been given at the appropriate times. Medicines were stored appropriately and clinic rooms displayed a good standard of housekeeping. Appropriate arrangements were in place for the management, administration and disposal of controlled drugs (CD), which are medicines which may be at risk of misuse. The nursing and neuro units had piped suction and oxygen available. Where regular oxygen was prescribed this was clearly indicated and full risk assessments were in place. We saw that temperature checks for refrigerators were recorded on a daily basis and all were within recommended levels. Temperature checks for all medicine storage rooms were noted to have exceeded 25 degrees Centigrade the safe storage temperature recommended by the British Pharmacological Society and the registered provider's medicines policy, during the last 6-8 weeks. We discussed this with the registered manager. The registered manager addressed this at the time of the inspection by arranging for air conditioning units to be installed in all medicine storage rooms. Staff who administered medicines were trained and required to undertake an annual competence assessment. This meant that the provider stored, administered, managed and disposed of medicines safely.

Good

Is the service effective?

Our findings

People who lived at The Hawthorns received care and support from trained and supported staff. People and their relatives told us, "The staff here are 100% better than [previous home]. Nothing's a bother. If they don't know something, they go and find out" and "It's marvellous here. If it hadn't been for this place my mam would have been dead".

We looked at the training records for seven members of staff. The records contained certificates, which showed that mandatory training was up to date. Mandatory training included moving and handling, fire safety, customer care, first aid, health and safety, control substances that are hazardous to health (COSHH), infection control and safeguarding. Records showed that most staff had completed either a Level 2 or 3 National Vocational Qualification in Care. In addition staff had completed more specialised training in for example, pressure ulcer prevention, cardiopulmonary resuscitation (CPR), end of life care, dementia awareness, brain anatomy, food allergens, dignity, equality and diversity, falls, safe use of bedrails, oral health, diabetes, sensory deprivation awareness and Non–Abusive Psychological and Physical Intervention (NAPPI), epilepsy, peg feeding, catheter care, ventilation and tracheostomy care.

We saw evidence of planned training in for example, dysphagia, cardiopulmonary resuscitation (CPR) and first aid training was booked for May 2016. Staff told us that training was important to them. The nursing staff we spoke with told us they had no problems accessing external training courses and the nurses on the neuro-rehab unit described the close links the service had with the Neuro services in Newcastle in relation to up-dating. The registered manager also told us she had identified a need for more person centred training for staff on the Seaham House unit. Staff files contained a record of when training was completed and when renewals were due. Records for the nursing staff showed that all of them held a valid professional registration with the Nursing and Midwifery Council.

We saw staff received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. This meant that staff were properly supported to provide care to people who used the service.

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. We looked at records and discussed DoLS with the registered manager, who told us that there were DoLS in place and in the process of being

applied for. Staff were provided with guidance regarding the Mental Capacity Act 2005, the DoLS procedures and the involvement of Independent Mental Capacity Advocates (IMCAs). We found the provider was following the requirements in the DoLS.

Mental capacity assessments had been completed for people and best interest decisions made for their care and treatment. For example, four people were in receipt of covert medicines. MAR's and care records were reviewed and there was evidence that 'best interest' decision meetings had taken place and recorded, involving the nursing team, doctor and pharmacist. This was in line with the registered provider's policy and National Institute for Health and Care Excellence (NICE) guidance on covert administration. Staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards and consent to care and treatment was documented in the care plan documents. There was evidence that relatives were aware of and involved in the care planning process. A relative told us, "Yes, we are kept up to date".

People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining rooms at meal times when required. People were supported to eat in their own bedrooms if they preferred. We saw a daily menu displayed outside the dining room and on each dining table which detailed the meals available throughout the day. We observed staff giving residents a choice of food and drink. A member of staff told us, "I am aware of those people who require special diets including diabetic, Halal, fortified and soft or pureed". We saw staff chatting with people who used the service. People who used the service and their relatives told us, "I had salmon for lunch. It was beautiful. I wish I could have eaten it all", "Food is lovely. Can't eat it all", "Her diet is fine. She eats very well", "Diet is good" and "She sometimes eats in her room, sometimes in the dining room. It's her choice".

The care records we looked at demonstrated people's weight and nutrition was closely monitored. We spoke with a cook who told us about people's special dietary needs and preferences. From the staff records we looked at, all of them had completed training in food safety. The service also holds monthly 'food forum' meetings with resident and relative input. This enables the staff to provide a menu which reflects personal choice, cultural expectations and nutritional value in response to individual circumstances. We looked at the minutes of the meeting held on 7 April 2016. Discussion items included suggestions for new menus, mealtimes, fruit bowls and coffee mornings.

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GP's, speech and language therapy, tissue viability, continence advisor, dietician, falls team, mental health services, podiatry, palliative care team, Macmillan nurses, opticians and community physiotherapy. We observed how staff had closely worked with healthcare professionals to successfully heal a person's skin pressure damage. This meant the service ensured people's wider healthcare needs were being met through partnership working.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. The home was suitably designed for people with dementia type conditions. For example, there was some colour coding and additional signage on the doors of toilets and bathrooms, and evidence of memorabilia around the unit as a reminiscence tool including theatrical posters and photographs. The registered manager told us about some of the plans for the service including refurbishing some of the communal areas, bathrooms and bedrooms.

Good

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the standard of care at The Hawthorns. They told us, "I am very well looked after", "I am very happy", "Yes, I am very happy. I've been here years", "The girls are lovely", "I'm well looked after. I love the girls", "As soon as I walked in I knew it was the right place for my mum. Very caring", "They are lovely, you can't fault it" and "The care is very good".

People we saw were well presented and looked comfortable. Staff knew people's names and spoke with people in a kind and caring manner. Staff interacted with people at every opportunity and were polite and respectful. We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. For example, we observed a member of staff say,
"Hello [Name], can I just come in and check how much you've had to drink?"

We saw staff assisting people, in wheelchairs and specialist chairs, to access the lounges, bedrooms and dining room. We also saw staff assist people to re-position in bed. Staff assisted people in a calm and gentle manner, ensuring the people were safe and comfortable, often providing reassurance to them. A relative told us, "Yes they do respect people's privacy and dignity. They are very good at that". The registered manager told us how the service planned to identify dignity champions amongst the staff team to further embed the dignity promise and how it was developing a training plan that focused upon improving practice in areas such as privacy, language and mealtimes. This meant that staff treated people with dignity and respect.

We saw people were assisted by staff in a patient and friendly way. We saw and heard how people had a good rapport with staff. Staff knew how to support people and understood people's individual needs. A relative told us "The staff know her. They know when to leave her alone". All the staff on duty that we spoke with were able to describe the individual needs of people who were using the service and how they wanted and needed to be supported. For example, staff told us, "[Name] loves gardening. [Name] told us they wanted a shed. They knew exactly what they wanted, including the measurements. We took [Name] to the [Retailer] to choose" and "[Name] likes to sit upright and likes to be smartly dressed, Once he gets to know you he's a lot more open and will talk to you, He's a lovely man". This meant that staff were working closely with individuals to find out what they actually wanted.

We saw the bedrooms were individualised, some with people's own furniture and personal possessions. We saw many photographs of relatives and occasions in people's bedrooms. All the people we spoke with told us they could have visitors whenever they wished. The relatives we spoke with told us they could visit at any time and were always made welcome.

A member of staff was available at all times throughout the day in most areas of the home. We observed people who used the service received help from staff without delay. We saw staff interacting with people in a caring manner and supporting people to maintain their independence. People were supported to go into the garden and staff sat and talked with them.

We looked at records and spoke with people who used the service, their relatives and staff and saw how the service celebrated special occasions or events. For example, arranging an Easter party with a buffet and entertainer and celebrating St Patrick's day with drinks, music and a quiz.

We saw Do Not Attempt Resuscitation (DNAR) forms were included in care records and we saw evidence that the person, care staff, relatives and healthcare professionals had been involved in the decision making. We saw end of life care plans, in place for people, as appropriate and that staff had received training in end of life care. This meant that information was available to inform staff of the person's wishes at this important time to ensure that their final wishes could be met.

We saw people were provided with information about the service in the 'Statement of Purpose' and in a 'service user guide' which contained information about staff, care planning and access to records, facilities and services, meals, social activities, privacy, dignity and resident's rights, Mental Capacity Act, Deprivation of Liberty Safeguards, religious services and cultural needs, fire precautions, emergency procedures, safeguarding, advocacy and complaints. Information about health and local services was also prominently displayed on notice boards throughout the home.

Good

Is the service responsive?

Our findings

We looked at care records for ten people who used the service. We saw people had had their needs assessed and their care plans demonstrated a good understanding of their individual needs. There was evidence of regular review, updates and evaluation.

Care plans had been developed from a person-centred perspective. This was evidenced across a range of care plans examined that included: hygiene and dressing, maintaining safety, communication, controlling body temperature, eating and drinking, elimination, mobility, recreation, breathing and sleep.

The neuro-rehab service included more complex assessments and formulations of people's needs including reports by the psychologist, physiotherapist and occupational therapist. Care plans contained people's photographs and their allergy status was recorded. Each care plan included a person's life history with input from relatives. This provided insight into each person including their social history, their likes and dislikes. This was a valuable resource in supporting an individualised approach and gave staff more detail in helping to communicate with some people who had limited or no communication.

Risk assessments had been completed with evidence across the care plans relating to falls, choking, skin integrity, moving and handling, weight loss, ventilation, suction, use of bedrails and pain management. This meant risks were identified and minimised to keep people safe.

We saw staff used a range of assessment and monitoring tools and kept clear records about how care was to be delivered. For example, Malnutrition Universal Screening Tool (MUST), which is a five-step screening tool, were used to identify if people were malnourished or at risk of malnutrition, Waterlow which assessed the risk of a person developing a skin pressure ulcer and body maps were used where they had been deemed necessary to record physical injury.

The service employed three activities co-ordinators. We saw planned activities were displayed on notice boards throughout the home and included movie afternoon, hairdressing, dominoes, shopping outing, trip to beach for fish and chips, baking scones, entertainers, pet therapy, music therapy and sing a long, newspaper discussion group, jigsaws and board games. Dates for Holy Communion were displayed on notice boards. The service also had 2 mini-buses that were regularly used for outings. The activity coordinators told us that they attempt to plan activities in advance although they recognised the need to be flexible and adapt the programme to meet the requirements of people who used the service.

During our visit we observed a lot of activities taking place including staff dancing with people who used the service and playing games, some were playing dominoes, others listening to music, some people were using the gardens. One person, who was very interested in gardening had been out with an activity co-ordinator to a gardening centre to buy bedding plants and some boots.

A person who used the service told us, "There is lots to do" and relative told us, "She loves the [Activities co-ordinator]. I play bingo with her". The registered manager told us how the service also planned to encourage

the use of volunteers in order to promote and develop additional activities and interests within the home, for example, volunteer run groups or 1:1 befriending. All volunteers would be interviewed, have undergone a DBS check, and would receive regular supervision from a named member of senior staff.

People were encouraged and supported to maintain their relationships with their friends and relatives. There were no restrictions on visiting times and relatives were encouraged to have meals in the home. This meant people were protected from social isolation.

We saw a copy of the complaints policy on display. It informed people who to talk to if they had a complaint, how complaints would be responded to and contact details for the local authority, the local government ombudsman, PCT and CQC, if the complainant was unhappy with the outcome. We saw the complaints file and saw that complaints were recorded, investigated and the complainant informed of the outcome including the details of any action taken. People and their relatives told us, "I am very happy, no complaints, "I have never had to make a complaint", "You won't find any problems here" and "I have no complaints". This meant that comments and complaints were listened to and acted on effectively.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The manager had been registered with CQC since 6 March 2015. CQC registration certificates were prominently displayed in the home's entrance. The registered manager had notified the CQC of all significant events, changes or incidents which had occurred at the home in line with their legal responsibilities.

The registered manager told us the home had an open door policy, meaning people who used the service, their relatives and other visitors were able to chat and discuss concerns at any time. Staff we spoke with were clear about their role and responsibility. They told us they were supported in their role and felt able to approach the manager or to report concerns. We spoke with a relative about the registered manager, they told us "Oh yes, she's wonderful".

The provider had a quality assurance system in place which was used to ensure people who used the service received the best care. We looked at the registered provider's audit file, which included audits of care documentation, health and safety, medicines, professional practice, kitchen, housekeeping and infection control. We also saw the registered providers divisional director had completed a 'quality first' audit on 6 and 7 April 2016 which identified whether the service was safe, effective, caring, responsive and well-led. All of these were up to date and included action plans for any identified issues.

The home had been awarded a "5 Very Good" Food Hygiene Rating by the Food Standards Agency on 19 February 2016, had received accreditation to Headway (the brain Injury association), member of the united kingdom brain injury forum (UKABIF), had received a quality assurance award from the NHS Oral Health Promotion Team for oral health on 9 July 2014 and were rated as 9.2 out of 10 by the care home.co.uk scheme which was based on the reviews of seventeen people who used services, relatives and friends.

People who used the service and their relatives told us they were regularly involved with the service in a meaningful way. They told us they felt their views were listened to and acted upon and that this helped to drive improvement. We looked at the minutes of the residents and relatives meeting held on 25 February 2016. Discussion items included social activities, future events and the laundry service. A relative told us, "I go to the relatives meeting. It's every month".

We saw the result of the 2015 'residents survey'. Themes included staff and care, home and comforts, choice and having a say and quality of life. The service scored 91% from twenty nine responses. A relative told us, "We get surveys. My brother deals with those". We also observed a suggestion box available in the main entrance for people who used the service or their relatives to post comments, complaints or compliments. The registered manager told us how the service was exploring the possibility of introducing a newsletter and proposed to introduce 'You said, We did' notice boards to provide feedback to people about their suggestions.

Staff meetings were held regularly. We looked at the minutes of a head of units meeting held on 13 April

2016. We found staff were able to discuss any areas of concern they had about the service or the people who used it. Discussion items included corporate and regional updates, sickness, appraisals, equipment, holidays and nutrition meetings. We saw the minutes of a clinical staff meeting held on 6 April 2016. Discussion items included nurse revalidation, staffing levels, training, drug assessment, nutrition, DoLS applications and clinical governance. We also saw the minutes of a staff meeting held on 23 April 2016. Discussion items included accident and incident reporting, budget and quality audit. Staff told us, "We have a high retention of staff and great teamwork" and "It's a brilliant place to work, that's why so many staff have been here for years". This meant that the provider gathered information about the quality of the service from a variety of sources and had systems in place to promote continuous improvement.

The service had policies and procedures in place that took into account guidance and best practice from expert and professional bodies and provided staff with clear instructions. For example, the registered provider's restraint policy referred to the Human Rights Act 1998, the Equality Act 2010 and the Mental Capacity Act 2005 and the infection control policy referred to guidance from the National Institute for Health and Care Excellence (NICE). The registered manager told us, "Policies are regularly discussed during staff supervisions and staff meetings to ensure staff understand and apply them in practice". The staff we spoke with and the records we saw supported this.

Records were maintained and used in accordance with the Data Protection Act and statutory notifications were submitted in a timely manner.