Care Quality Commission

Anchor Trust

Ashcroft Nursing Home - Bradford

Inspection report

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Date of inspection visit: 17 November 2015
Date of publication: 21/12/2015

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

Overall summary

Ashcroft Nursing Home provides accommodation and personal care for up to 67 older people at any one time. The home is spread over three floors with a dementia unit on the ground floor and a general residential unit on the 1st floor. At the time of the inspection the lower ground floor was not open and was undergoing redevelopment.

This was an unannounced inspection which took place on 17 November 2015, 55 people were living at the service.

At the previous inspection in November 2014, we identified a breach of Regulation 20 of the Health and

Summary of findings

Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found improvements had been made and the provider was no longer in breach of any of our regulations.

A registered manager was in place. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

People and their relatives told us the service provided safe and appropriate care and treatment. Safeguarding procedures were in place and we saw evidence these were followed to keep people safe. Risks to people's health, safety and welfare were well managed by the service.

There were enough care staff deployed to ensure people were cared for safely and provided with regular social interaction.

Medicines were safely managed. Staff thoroughly checked medicines before administration to help reduce the risk of errors. People received their medicines at the times they needed them.

People told us that staff had the right skills to care for them. Staff received regular training updates in a range of subjects. Staff we spoke with demonstrated a good knowledge of the people and subjects we asked them about, indicating training was effective.

Since the last inspection, significant areas of the building had been refurbished. The environment was pleasant and well maintained and contained a number of different communal areas where people could spend time.

Following the last inspection the service had opened a dementia care unit on the ground floor. The registered manager had implemented an effective and person centred approach to dementia care. Staff had been provided with dementia, dignity and delirium training and adaptions had been made to the environment to make them more dementia friendly.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act (MCA).

People spoke positively about the food provided by the service. We saw people were given sufficient choice and provided with regular snacks throughout the day. Appropriate action was taken by the service where people were deemed to be at risk of malnutrition.

Effective links had been developed with external health professionals to ensure that people's healthcare needs were regularly monitored.

People and their relatives said staff were always kind and caring and treated them well. We observed care and support and saw this was the case. Staff were familiar with the people they were caring for and were aware of their likes and preferences.

People's needs were thoroughly assessed to assist in the delivery of appropriate care. On reviewing care records, speaking with people and staff we concluded that people were receiving appropriate care which met their individual needs.

A range of activities were provided to people. Activities co-ordinators were employed by the service and social interaction was supplemented by volunteers and students on placements at the home.

On reviewing records and speaking with people and their relatives we concluded people experienced a high level of satisfaction with the service. A system was in place to record, investigate and respond to any complaints received.

People and staff spoke positively about the way the home was managed.

Systems were in place to assess, monitor and improve the service. This included regular audits conducted by team leaders, the registered manager and senior managers. We saw these regularly identified issues and were effective in driving continuous improvement of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. People told us they felt safe living in the home and comfortable in the company of the staff that supported them. Risks to people's health and safety were appropriately controlled to help keep people safe. Medicines were safely managed and people got medicines at the times they needed them. There were enough staff available to ensure safe care and appropriate social interaction.	**Good**
Is the service effective? The service was effective. Staff had received a range of training which supported them in their role. Staff displayed a good knowledge of the people they were caring for. People spoke positively about the food at the home. We saw a varied menu was provided which was supplemented by regular snacks. Adaptions had been made to the premises to make it more dementia friendly. A number of initiatives had been put in place to help provide person centred and effective dementia care.	**Good**
Is the service caring? The service was caring. All the people we spoke with said staff were kind and caring and treated them with dignity and respect. This was confirmed in the interactions we saw between staff and people who used the service, where it was clear good relationships had been developed. Care plans demonstrated people had been asked for their views on how they wanted their care to be delivered and their likes, dislikes and personal preferences.	**Good**
Is the service responsive? The service was responsive. People's needs were thoroughly assessed through the pre-admission process and on moving to the home a range of suitable care plans put in place for staff to follow. Staff were aware of people's needs and how to deliver appropriate care. A range of activities was provided to people by dedicated activities staff and supplemented by volunteers and a student placement programme. Systems to record, investigate and resolve complaints were in place.	**Good**
Is the service well-led? The service was well led.	**Good**

Summary of findings

People and staff spoke positively about the way the home was run and said the registered manager was friendly, approachable and supportive.

Systems were in place to assess, monitor and improve the service. We saw these had been effective in driving a number of recent improvements to the service, including improvements to the care approach and documentation.

There were several mechanisms in place to involve people in the running of the service and use their views and opinions to further improve service provision.

Ashcroft Nursing Home - Bradford

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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also checked whether improvements had been made following our previous inspection in November 2014 where we identified a breach of regulation relating to the inconsistent completion of care records.

The inspection took place on 17 November 2015 and was unannounced. The inspection team consisted of two inspectors 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, in this case experiences of services for older people.

We used a number of different methods to help us understand the experiences of people who used the service. We observed care and support in the lounge and communal areas of the home. We spoke with ten people who used the service, two relatives, eight care workers, two team leaders, the cook, a cleaner, the registered manager and the deputy manager, We looked at a seven people's care records and other records which related to the management of the service such as training records and policies and procedures.

On this occasion, we did not ask the provider to complete 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. However, we reviewed all information we held about the provider.

Before the inspection we contacted the local authority to get their views on the service.

Good

Is the service safe?

Our findings

People told us they felt safe in the home. They all said staff were kind, friendly and treated them well. Safeguarding procedures were in place, which were well understood by care workers and the management team. We saw evidence these procedures had been correctly followed, for example, referrals had been made to the Local Authority and notifications sent to the Commission. Where concerns had been identified, the registered manager was quick to undertake thorough investigations and ensure measures were put in place to keep people safe and help prevent a re-occurrence. Disciplinary processes were followed where appropriate to help keep people safe.

Clear reporting mechanisms were in place to ensure staff reported incidents and accidents. All incidents were investigated by the registered manager with clear preventative measures put in place to prevent a re-occurrence. Where behaviours that challenged had occurred between people who used the service, we saw prompt action had been taken. This included reviewing care plans and seeking the advice of external health professionals. This helped ensure people were cared for safely.

Where risks to people were identified, risk assessments were put in place to guide staff on how to deliver safe care and protect people from harm. These included moving and handling, falls and any specific risks identified to the individual such as diabetes or behaviours that challenged. We found the service was responsive in reviewing these risk assessments following incidents, for example, falls. We saw examples of these risk assessments being followed, for example, staff working to moving and handling care plans to ensure the safe hoisting of people. People and their relatives told us that staff undertook moving and handling competently, for example, one relative told us, “When they put him in his wheelchair they are always careful when using the hoist.”

People and staff told us there were enough care staff working within the home to ensure safe care. Observations of care and demonstrated there were sufficient staff to ensure people were provided with timely care and regular social interaction. Staff were visible in communal areas such as the lounge to ensure people were appropriately supervised and their requests responded to. We did find some instances of staff being slow to respond to call bells, although some of this was down to the buzzer sounding when doors were opened rather than when people required care. The registered manager told us a new call system was to be installed in the near future which would reduce this problem and improve the time taken by staff to respond to people’s requests for assistance. Sufficient quantities of management and ancillary staff such as cleaners, kitchen staff and maintenance staff were deployed to help ensure the safe management of the service.

The provider had a policy and procedure document in place relating to the safe administration and storage of medicines. We looked at medicines with the team leaders on duty. We saw medicines were supplied from the pharmacy mainly in a monitored dosage system (MDS), or where this was not appropriate, in boxes and bottles. Medicines, including controlled drugs, were stored securely in a locked clinical room. We found appropriate arrangements were in place for the ordering and disposal of all medicines. A medicine fridge was used for medicines requiring cold storage and fridge and room temperatures were monitored and recorded daily.

We saw protocols were in place for medicines prescribed “as and when required” (PRN) which provided guidance to staff about under what circumstances the medicines should be administered.

Staff confirmed that no one was administered medicines covertly or administered their own medication. However, staff said if people had the capacity and wished to administer their own medicines they were encouraged to do so within a risk management framework.

We found overall medicines were safely managed and people received their medicines as prescribed. Medicines were administered by trained care staff who demonstrated a good level of awareness of the medicines they were administering. We saw staff carefully checked medication prior to administration to ensure people were receiving the correct medication. Arrangements were in place to ensure medicines were given at the correct time. For example, we saw that where medicines needed to be administered before breakfast this was undertaken by night staff. Where people refused medication we saw this had been appropriately recorded and discussed with the prescriber.

We looked at medication administration record (MAR) sheets. In all but one case, we saw that medication records

Good

Is the service safe?

did not have any gaps in the signatures, and stocks of medicines tallied with what was recorded, demonstrating that medication had been given correctly. In one person's records, we identified a missing signature and on counting the number of tablets in stock established that on one date the person had not received their medicines as prescribed. We concluded this was an isolated incident and the manager began an immediate investigation into this incident. We saw where previous medicines errors had been identified appropriate action had been taken by the provider to investigate and learn from these types of incidents.

We saw medicines were given in a friendly manner by staff who explained to people what the medicines were for and asked their consent. People confirmed this was the case, for example one person told us, "The staff are all nice and the nurse comes to give me my medication she always waits and chats until I have taken it."

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw that controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

We completed a tour of the premises and inspected a number of bedrooms as well as bathrooms and communal living areas. We saw since the last inspection many areas had been refurbished and now looked bright and airy. We also saw many people had personalised their rooms with small items of furniture, pictures and ornaments which made them look homely. There were plans in place to further develop the building, for example, in the creation of an old fashioned barbers shop. Bedrooms were suitable spacious and work had been undertaken by management to decommission unsuitably sized rooms. There were a number of communal areas where people could choose to spend time. This included a choice of dining rooms, choice of lounges including a quiet lounge and a recently opened café area

We saw fire-fighting equipment was available, emergency lighting was in place and all fire escapes were kept clear of obstructions. We found all floor coverings were appropriate to the environment in which they were used and properly fitted ensuring no trip hazards existed. We also reviewed fire safety records and maintenance certificates for the premises and found them to be compliant and within date. Maintenance staff were employed who managed the maintenance of the premises and conducted safety checks for example on water temperatures, fire equipment and lifting equipment.

We found the environment to be clean and we did not encounter any offensive odours during the inspection. People told us the home was kept clean and did not raise any issues about cleanliness, for example, one person told us "A lady comes round and sweeps up all the time every day it is very clean here." Infection control checks were in place and infection control champions had recently been appointed to promote good infection control practice.

Robust recruitment procedures were in place. These included ensuring a DBS (disclosure and baring service) check was undertaken, checks on previous qualifications and references were obtained before staff commenced employment. Staff attended a formal interview before being offered a position with the organisation. We spoke with new members of staff who confirmed they had to await the relevant checks before they started work which showed the recruitment procedures were being applied.

Good

Is the service effective?

Our findings

People and their relatives all told us that people received effective care. For example one person told us, "They do look after me though and they know my needs."

People told us staff were competent and had the required skills and knowledge to care for them. Staff were provided with a range of mandatory training on an annual basis to maintain and develop their skills. We looked at training records which showed the majority of staff were up-to-date with mandatory training, for example, the overall compliance rate was 94%. This included training in relation to The Mental Capacity Act (MCA), safeguarding, moving and handling, medications and person centred care planning. Competency tests formed a part of some training to check staff had the required skills and knowledge to deliver care effectively. The registered manager ensured a varied programme of specialist training was also provided to staff to increase their skill base. For example, training in pressure area prevention, alcohol awareness and diabetes training had been provided to some staff.

Arrangements were in place to provide staff with appropriate induction training. New staff without previous care experience were required to complete the Care Certificate. This provides staff with a structured training programme which meets national standards. New staff who had previous care experience were required to complete a comprehensive induction which ensured they were aware of the company's ways of working and values of the organisation. These staff were also required to complete range of training which included dignity, dementia and moving and handling.

Staff spoke positively about the training they were provided with and said it had been useful in ensuring they were suitably skilled. We found staff had a good knowledge of the subjects and people we asked them about indicating this training had been effective.

Staff had regular supervisions and annual appraisals to ensure their performance, worries or concerns and developmental goals were identified and discussed as part of a programme of staff support.

The service had recently opened a dementia unit on the ground floor of the building. We found the registered manager had implemented a philosophy of care adapted to the needs of people living with dementia. Staff had been provided with appropriate training to help ensure they had the correct skills to care for people living with dementia. Dementia awareness training had been provided to all staff and all team leaders had completed more extensive level 2 training in dementia. Training in understanding and managing delirium had also been provided so staff could understand the signs, causes and how to assist to reduce any distress associated with delirium. Additional training in dignity had been provided to some staff and dignity champions had been appointed. Our observations of care showed staff interacted well with people living with dementia which demonstrated training had been effective.

Adaptions had been made to the premises to ensure it was suitable to provide good dementia care. These included the provision various communal areas including quiet areas where people could spend time. There were features such as a purpose built café with pictorial memories displayed from the 1920's to 1940's, pictures on bedroom doors and contrasting colours used on toilet doors to help orientate people to the environment.

A number of other initiatives were in place to ensure good dementia care. For example staff wore pyjamas at night to help orientate people to the fact that it was night-time and an appropriate time to sleep. The service also provided dementia awareness training for people who used the service. This helped people to understand how dementia manifests itself.

Where people displayed distress reactions or behaviours that challenge we found positive behaviour support plans were in place which detailed how staff should positively support people to reduce distress. These included appropriate diversion techniques. Staff we spoke with understood these plans. Where behavioural incidents had taken place we saw these were recorded and appropriate preventative measures had been put in place.

People spoke positively about the food and their comments demonstrated there was a good choice of options available at each mealtime. For example, one relative told us, "The food is very good here and he loves his food." Another person told us, "I like the food here, Toast, Porridge, Tea and Cranberry Juice for my breakfast" and another person told us how they got a cooked breakfast each morning. We saw arrangements were flexible to ensure breakfast was served at a time that met their individual preferences.

Good

Is the service effective?

We saw a range of options were available to people at lunchtime and for the evening meal. Menus rotated on a 4 weekly cycle to ensure a variety of suitably nutritious food was provided. We observed the lunchtime meal and saw people were offered choices and the atmosphere was informal and relaxed. Food looked appetising and was well presented. Special diets were catered for such as reduced sugar content for diabetics. We saw if people required staff to assist or prompt them to eat their meal this was done discreetly and staff did not rush them or leave them until they had finished their meal. We saw, since the last inspection, the dining facilities had been improved and provided people with a pleasant environment to eat their meals. The staff we spoke with confirmed that meal times were now a much more social event and many people enjoyed using the dining room instead of having meals in their private accommodation.

We spoke with the head chef and it was apparent that they were aware of people's dietary needs and individual preferences. The head chef confirmed that either they or a member of the catering team always serve out the lunchtime meals on both the residential and dementia care unit and attended residents meetings to get feedback on the mealtime experience. Taster sessions periodically took place to trial new foods and see whether future menus would be well received.

The service promoted snacks throughout the day. For example, we saw that after lunch one person wanted something to eat and was given a range of options from which they chose some chocolates which were well received by the person. In addition a tea trolley with biscuits and cakes went round each morning and afternoon as well as an old fashioned sweet trolley in the afternoon. People were provided with supper later in the evening. In addition to these being pleasant additions to the care and support they were also good mechanisms to ensure people were provided with sufficient calorific intake.

We saw nutritional risk assessments were completed on admission and people's weight was monitored. The staff we spoke with told us they monitored individual people's food and fluid intake if they had concerns and involved other healthcare professionals if appropriate. Care records confirmed that where nutritional concerns were identified appropriate action was taken including increased weight monitoring, monitoring of food intake and refer onto external health professionals.

Where people's food and fluid intake was being monitored we found these were generally well completed. In a couple of cases we found charts were not fully completed. This was discussed with the registered manager who told us that they were confident people did receive sufficient to eat and drink but acknowledged staff had failed to complete the charts to evidence this. They confirmed this matter would be addressed immediately.

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)

DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty. We found this had been generally been undertaken where appropriate by the service. We were told that two people using the service were subject to authorised deprivation of liberty and a further ten applications had been made which were waiting for assessment from the supervisory body. Our scrutiny of people's care records demonstrated that all relevant documentation had been completed. Where conditions were stated in DoLS Authorisations we saw these were being met.

Where DoLS applications had been made, additional care plans were put in place to help protect people's freedom and ensured the least restrictive options were deployed.

The registered manager demonstrated a good understanding of the safe application of DoLS which gave us assurance that the correct processes would continue to

Good

Is the service effective?

be followed. However, some staff were not aware of who had DoLS authorisations in place. This meant there was a risk staff would not be aware of any conditions in place to protect people's rights.

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. Where people lacked capacity to make the own informed decisions, we saw evidence a best interest processed had been held with family members and health professionals. This showed the correct procedures had been followed in line with the legal framework of the MCA

People told us that staff were good at meeting their healthcare needs and that they had access to a range of health professionals. For example, one relative told us, "The staff know him very well and can tell by his actions or facial expression if he is not feeling very well." Another person told us, "The Doctor and nurses are always coming round they are excellent, I get health checks when needed." A third person told us, "The GP comes in every Thursday to visit people." We saw evidence in people's care files of regular contact with external health professionals such as GP's, dieticians and district nurses. This provided evidence that any changes in people's health were promptly identified and action taken to ensure their healthcare needs were met. People were provided with appropriate equipment to manage any healthcare needs such as cushions and mattresses for people who were at risk of developing pressure sores. We saw these were appropriately used and managed well by staff.

Good

Is the service caring?

Our findings

People told us they were treated with dignity and respect by kind and compassionate staff. Nobody raised any concerns about the way they were treated within the home. For example, one person told us, “Everyone is very caring. The staff do listen to me, and they ask and explain about my care and medication with my daughter too.” Another person told us, “I get looked after here” and a third person said, “The staff are excellent I cannot fault the care I receive.” A relative told us, “It is very nice here, very welcoming when I arrive, they all know me and my Brother is happy and cared for and this is the main thing.”

We observed care and support. People looked clean and well-dressed which indicated that their personal care needs were met. Staff were caring and patient in their approach and supported people in a calm and relaxed manner. They stopped to chat with people and listened, answered questions and showed interest in what they were saying. During care and support, such as hoisting, staff took the time to explain to people what was happening and provided assurance to alleviate any anxiety.

We saw staff addressed people by their preferred name and always asked for their consent when they offered support or help with personal care. Staff knew what people were able to do for themselves and were able to supported them to remain independent as possible. Staff we spoke with told us that they respected people’s privacy by ensuring they knocked on bedroom doors and spoke to people when entering. One staff member told us, “When I am helping a person with personal care, I always make sure the bathroom or bedroom door is closed.” We saw evidence of this during the course of the inspection.

During the inspection we saw it was someone’s birthday and staff made efforts throughout the day to make the person feel special, spending time with them and provided them with a birthday cake. This demonstrated a caring and person centred approach to care.

Care records contained information on people’s likes, dislikes, preferences and biographies. This demonstrated the staff had taken the time to speak to learn about people to aid in the delivery of personalised care. Discussions with staff revealed a caring and kind team who were motivated to care provide a high level of care and support for vulnerable people. Staff had developed good relationships with people and demonstrated to us that they understood people’s likes, dislikes and individual preferences.

To ensure people were provided with a high level of dignity and respect 13 dignity champions had recently been appointed. These staff had completed a three day intensive course in dignity. Each staff member was asked to focus on championing one area of dignity improvement within the home. We spoke with two dignity champions who were motivated in their role and were able to give examples of specific steps they were taking to improve the dignity for people living within the home. Regular monthly dignity meetings took place to discuss progress in continuously improving dignity.

The registered manager was in the process of implemented the Gold Standards Framework (GSF) to help improve the quality of life for people received End of Life Care. Four staff had attended GSF meetings and were the GSF champions for the service to promote good end of life care. End of life care plans were in place where appropriate to help staff provide compassionate care.

Care records demonstrated the service regularly communicated with relatives about any changes in people’s needs or any specific incidents. Relatives we spoke with said communication was good and they felt involved in care planning. People and relatives said there were no restrictions on visiting the service.

Mechanisms were in place to listen to people. These included periodic care reviews, and informal methods such as through the registered manager’s daily walk around, suggestions box and dining experience comments book.

Good

Is the service responsive?

Our findings

People and their relatives told us that care was appropriate and met people's individual needs.

We looked at the care documentation for seven people who used the service and found the care plans in place were generally person centred and provided staff with the information they required to meet people's needs.

The pre-admission assessment used by the service showed family members had been involved in the assessment process. The assessment identified people's needs and what was important to them. The assessment contained a high level of detail demonstrating their needs and care requirements had been thought about it depth before the person moved to the home. This helped to ensure appropriate care was delivered as soon as people started using the service.

Following admission, where specific needs had been identified, care plans and risk assessments were put in place. These provided detailed information about how best to support the person including how to meet people's communication, mobility, personal care, social and dietary needs. Care plans had a focus on ensuring people could maintain independence where possible. They included person centred information on people's likes and dislikes.

Care plans were reviewed monthly or sooner if people's needs changed significantly. There was evidence that wherever possible people who used the service and/or their relatives were involved in reviewing their care plans.

The care staff we spoke with told us the care plans provided them with clear information and guidance on how to meet people's needs. Throughout the time of our inspection we saw staff responded appropriately if people requested assistance or support. We saw people were involved in their care and staff always explained what they wanted to do and asked for people's consent before carrying out care or giving support.

We saw that the daily records completed by care staff were generally completed to a satisfactory standard. However, we saw for one person who had fallen and had attended the Accident and Emergency Unit the daily records had not been completed correctly. This was discussed with the registered manager who acknowledged that staff had failed to complete the daily report correctly and told us they would address this matter through supervision and training.

The service was sensitive to people's individual cultural and religious needs. For example, in meeting special dietary requirements and providing cultural appropriate food where a need was identified.

Activities staff were employed to provide people with a range of activities and social interaction. The service had developed links with local colleges to support and develop students within the home. We saw a student was present during our inspection which allowed additional social interaction to be provided to some people who used the service. Social interaction and activities were also supplemented by a network of volunteers

People spoke positively about the activities provided and said three was enough to do. One person told us, "An activities lady comes every morning, there is enough to do." We observed activities and saw they were well received; these included a range of games including Bingo and music. A bespoke activities rota was in place for December which included a range of Christmas based activities and religious services.

We saw the environment was conducive to providing people with opportunities to interact. There was a café area with a memory board with material from the 20's, 30's and 40's which provided stimulation to people. This area was also used to provide a public community event each month to maintain links with the local community.

We looked at the complaints policy which was available to people who used the service, visitors and staff. The policy detailed how a complaint would be investigated and responded to and who they could contact if they felt their complaint had not been dealt with appropriately. The policy also detailed the timescales within which the complainant would be dealt with. People who used the service told us they knew how to make a complaint but had never had the need to use the formal process. One person told us, "I feel something is not right I tell the staff straight away and they always sort it out, but it very rare I have anything to complain about."

Good

Is the service well-led?

Our findings

A registered manager was in place. Statutory notifications were appropriately submitted to the Commission, for example, deaths and any serious injuries. Following these notifications, if requested, the service promptly provided the Commission with any additional information.

We observed there was a pleasant, relaxed and friendly atmosphere within the home. The staff team spoke positively about the way the home was led. They told us that the registered manager and senior management team operated an open door policy and were confident that any issues they raised were dealt with promptly. They told us the registered manager was approachable and the care, treatment and support people received had improved significantly under their leadership and direction.

It was apparent that the registered manager had made a number of improvements to the service since taking up post and was committed to ensuring the quality assurance monitoring systems in place were robust and fit for purpose. We found an improved staff structure was in place with clearly defined responsibilities around areas such as audits, checks and supervision. Staff morale, care documentation and person centred approaches to care and support had all been improved under the registered manager's leadership. The registered manager had worked hard in implementing a person centred philosophy of care which was adapted to the needs of people who lived with dementia

We found the registered manager was open and honest with the inspectors about where they recognised improvements were still required and had a clear vision about how they wanted the service to develop in the future.

Champions had been appointed in a number of areas to promote and improve practice in these areas. For example, dignity and infection control champions. Although these initiatives were in their early stages there was evidence they were helping to drive continuous improvement within the service. The registered manager was also able to call on expertise within the provider to seek specialist advice around subjects such as dementia and delirium to improve the quality of the service.

Various mechanisms were in place to listen to people and act on their views. For example, there was a dining service comment book where comments in relation to the mealtime experience were recorded. We saw where negative comments had been received these had been discussed with catering staff. People were asked to complete an annual satisfaction survey. We saw the result of this had been received and a "You said, We did" communication was displayed showing what action had been taken to address people's comments and ensure continuous improvement. Periodic resident meetings were held. We saw these provided an opportunity for people to discuss a range of areas including the dining experience, activities and complaints. In addition, there were more informal systems to seek people's feedback including a daily walk around by the registered manager.

A range of audits and checks were undertaken as a part of a system to assess, monitor and improve the quality of the service. These included audits of the dining experience, infection control, medication and care plans. We saw these were regularly identifying issues, for example, deficiencies in care plans were identified through a detailed care plan audit, and action points assigned to staff to ensure the necessary amendments were made. Specialist input was sought in some audits, for example, external medication audits were undertaken by a pharmacist. We saw these were effective in driving and maintaining a good quality service.

At the last inspection we identified issues with the completion of some daily charts. A new audit system was in place to ensure these charts were audited on a daily basis We saw these had generally been effective in improving the quality of these documents, although there were still some minor inconsistencies which needed to be addressed. In addition, the registered manager had put in a range of additional checks which were completed by night staff, such as medication charts audits.

Provider visits were undertaken by the area manager which looked at the overall performance of the service. These provided assurance to senior management on the quality of the service. We saw these audits regularly identified issues and actions were assigned to the service and signed off by the registered manager once they had been completed.

Mechanisms were in place to ensure key performance indicators such as complaints, incidents and pressure sores were robustly monitored. Team leaders were required to

Good

Is the service well-led?

complete end of week reports within their area of responsibility. The service was required to submit information on key performance indicators to senior management as part of a system of good governance.

Following incidents and accidents, route cause analysis was undertaken. Falls analysis was undertaken to look for any trends, for example, themes around the person, time or location of falls. Where any trends were identified, these were analysed and a description of any preventative measures recorded.

Regular staff meetings took place. These included team leader meetings, head of department meetings and staff meetings. We saw evidence quality issues were regularly discussed to aid in continuous improvement of the service.