Barchester Healthcare Homes Limited

Kingfisher Lodge

Inspection report

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Date of inspection visit: 18 and 19 November 2014
Date of publication: 04/02/2015

Ratings

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

Overall summary

Kingfisher Lodge is a care home which provides nursing and personal care for up to 60 people, some of whom have dementia. At the time of our inspection, 47 people were resident at Kingfisher Lodge, 20 people in the Lark unit [memory lane] and 27 people in the Chaffinch unit.

This inspection took place on 18 November 2014 and was unannounced. We returned on 19 November 2014 to complete the inspection.

There was a registered manager in post at the service. 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 and associated Regulations about how the service is run.

The service did not have adequate numbers of staff available at all times to meet people's needs. This increased the risk of potential neglect due to the length of time people had to wait to receive care and support.

People and their families were positive about staff and the registered manager. People had developed caring relationships with staff and were treated with dignity and respect.

Summary of findings

Staff worked closely with health and social care professionals for guidance and support around people's care needs. The care records demonstrated that people's care needs had been assessed and considered their emotional, health and social wellbeing. People's care needs were regularly reviewed to ensure they received appropriate care, particularly if their care needs changed.

Training was available to ensure that staff had the necessary skills and knowledge to be able to support people appropriately and safely. There were systems in place to ensure that staff received support through supervision and an annual appraisal to review their on-going development.

There were clear values about the quality of service people should receive and how these should be delivered. The registered manager said "it's about taking a holistic view of the person and their family, offering a consistent person centred service, which is effective and reflects the needs of the person". Staff told us they valued the people they cared for and strived to provide a high quality of care. Relatives were confident that they could raise concerns or complaints and they would be listened to. Two thirds of staff thought the management team were approachable.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The staffing levels available did not enable people to receive their care in a timely manner. This posed a potential risk of neglect due to people having to wait for support.

People said they felt safe and relatives said they had no concerns regarding safety. Staff felt the people they supported were safe although they were concerned they were not always able to respond to people as quickly as they would have liked.

Staff were confident in recognising safeguarding concerns and potential abuse and were aware of their responsibilities in protecting people.

Is the service effective?

Good

This service was effective. People were supported by skilled and knowledgeable staff. Staff received regular supervision and an annual appraisal which identified on-going training needs and development.

People were supported to have enough to eat and drink. Where required, people had access to specialist diets.

Staff supported people to express their views and wishes and to be involved in their care. Guidance was available to staff and other professionals on how to most effectively communicate with the person.

Is the service caring?

Good

The service was caring. People told us that staff were caring and kind. Staff interactions with people demonstrated genuine affection. Care staff told us they cared about and valued the people they supported.

Staff knew people well and were aware of their preferences including the way their care should be delivered, their likes and dislikes.

Staff listened to people and acted upon their wishes. Staff supported people to make their own decisions about their day to day life.

Is the service responsive?

Good

The service was responsive. People received care and support which was specific to their wishes and responsive to their needs.

The activities co-ordinator spent time with people on a one to one to prevent people from becoming socially isolation. There were opportunities for people to take part in social activities if they wished to participate.

Summary of findings

Care records identified how people wished their care and support to be given and people told us they were happy with their care and support. Care records were person centered and had taken into account the person's individual needs, including: personal care, health and social wellbeing.

The home worked proactively with professionals from health and social care to ensure that people achieved the best possible outcomes for their health and wellbeing.

Is the service well-led?

Good

The service was well led. There were clear reporting lines from the service through the management structure. All staff shared the vision and values of the service in delivering a high quality of care.

Professionals said they found the home to be "open and transparent and willing to address any recommendations for improving the service". Two thirds of staff felt that the management team were approachable and one third of staff did not. All staff felt supported in their role by their respective line manager.

The provider had systems in place to monitor the quality of the service provided and to promote best practice.

Kingfisher Lodge

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 the 18 and 19 November 2014 and was unannounced.

The inspection was completed by 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.

Before the inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification form which they are legally required to complete. We asked the provider to submit 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. This enabled us to ensure we were addressing potential areas of concern.

During the inspection we spoke with 15 people who use services and eight relatives. In total, we spoke with 16 members of staff; these were the registered manager, the regional director, receptionist, chef, maintenance manager, the activities co-ordinator, one volunteer, two dining room hostesses, two registered nurses, three care assistants and two senior care staff. Before our visit we contacted professionals who visit the home to find out what they thought about the service provided. We contacted the local authority commissioning team and three health professionals.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to assist us to understand the experiences of the people who could not talk with us. We spent time observing people in the dining room and communal areas.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking to people, their relatives, looking at documents and records that related to people's support and care and the management of the service. We reviewed the care records of eleven people and tracked the care of four people to ensure they received the care in line with their care plan.

We interviewed ten staff and observed a registered nurse administering medicines to people. We looked at the recruitment records of two staff and supervision records, the staff training matrix and staff rotas, the companies' policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day.

Requires Improvement

Is the service safe?

Our findings

Relatives told us they felt their family members were safe living at the home. One relative said "I know they are alright here. If I have any issues I can pick up the phone. I don't need to worry about their care". People in Chaffinch and Lark units told us they felt safe with the staff that supported them with their care.

The provider had appropriate policies and procedures in place to protect people from abuse, such as safeguarding and whistleblowing policies, reporting procedures and incident tracking. However, the current procedure in place for calculating the staffing levels required in each unit were not effective. The procedure used did not provide adequate numbers of staff to meet people's needs in a timely manner.

Through our observations and discussions with people, we found there were not enough staff available at all times to meet people's needs, particularly around meal times. Whilst we found that during the inspection there were no incidents relating to a lack of staff, the impact of the current staffing levels meant that people had to wait until a member of staff was available to help them. We saw this caused distress and agitation amongst some people who used the service.

Eight members of staff thought the current level of staffing was inadequate. One staff member described their working day as, "being on a treadmill". Another member of staff said "it puts a lot of pressure on us". Staff said there were not enough care workers to be able to respond to people's needs quickly enough, although staff thought that people were safe. Three relatives told us the lack of care staff resulted in their family member not receiving timely care and support. We observed when people did receive care that staff did not rush them and gave the attention and support the person required.

During lunch time in the Lark unit, we saw one person waited 20 minutes until a member of staff was available to support them to eat and drink. Another person sitting on the same table had finished their main meal in this time. A third person had been given their starter of soup which was hot. The care worker had moved the soup out of the person's reach to let it cool down, however, they were not able to re-join the person to assist them until 15 minutes later. In this time, the person became agitated as they watched other people in the dining room eating and tried repeatedly to reach the soup. At tea-time, we saw this pattern of people waiting repeated.

In the Chaffinch unit dining room, people were waiting until staff were available to assist them to eat. We saw a care worker supporting a person to eat their meal. At the same table, three other people were waiting for the same care worker to assist them. The care worker had covered up the bowls of soup to keep them warm until they were available. People were sat passively watching the one person eating. During another observation we saw a member of staff leave a person halfway through assisting them to eat to deal with another issue. This person's relative had just arrived so took over. They told us "it would have been nice if I had been able to take my coat off and have a cup of tea".

In the Lark unit in the afternoon, we heard a person asking a care worker if they could help them get ready for bed. The care worker responded that they were "helping someone to eat their lunch and if they helped them, the person's meal would get cold". The care worker escorted the person to their room and suggested they try to get themselves ready for bed. Later, the same person asked us to help them. They told us they wanted their continence pad changed and to go to bed. We could not find care staff available and asked the registered nurse who was in the lounge if there was a care worker to help this person. They told us that they could not leave the people in the lounge as there was no-one else to take over. The registered nurse told us that one care worker was sited at the other end of the floor as required due to the length of the hallway, another care worker was helping a person and other staff were on their break. The person was supported when the care worker returned from their break ten minutes later.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Before our inspection, we asked health and social care professionals for their opinion of the service and were told by two professionals they had some concerns around the level of staffing, particularly at weekends.

When asked, the registered manager told us they had a set staffing ratio based upon the number of people in the home. We checked the staff rota's for the months of September and October 2014 and found that the number set for each shift was being met. In people's care plan we

Is the service safe?

saw that the number of staff required to support the person with their personal care, mobility and health care was documented. However, the current procedure used to calculate staffing levels did not take this into account. Care staff told us that many people in the Lark unit required two members of staff to support them but felt there were not enough staff to meet this.

The regional director explained the Barchester Healthcare group were piloting a 'dependency tool' to calculate staffing levels based upon people's needs. The registered manager and regional director acknowledged there were shortfalls in the current procedures and hoped to be soon using the new dependency tool to calculate their staffing needs. More recently they had started to review staffing numbers and confirmed there was to be an increase in care staff numbers on the Chaffinch unit, from five to six.

There were clear recruitment processes in place to ensure that new staff were safe to work with people. We looked at the employment files of two new members of staff. Each file had evidence that an application form had been completed and contained documents relating to the person's employment history. In addition, a Disclosure and Barring Service check (DBS) had been carried out before employment began. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

Staff had access to safeguarding training and guidance to help them identify abuse and respond appropriately. They told us they had received safeguarding training. Training records confirmed this. All of the staff were able to describe what constituted abuse and what action they would take if they suspected abuse. Staff told us they felt confident in raising any concerns about poor practice through the provider's safeguarding and whistleblowing procedures. All staff were confident that the registered manager would act on their concerns.

The safeguarding records demonstrated that the provider took appropriate action in reporting concerns to the local safeguarding authority and acted upon recommendations made. There was a low level of incidents and accidents and these were monitored by the manager and quality assurance team on a regular basis.

In the nurses station [in both units] we saw a floor plan which marked out where falls had occurred. The care staff told us this was used to put preventative measures in place to minimise further incidents, such as more frequent checks by staff or a chair for the person to rest and sit. Records demonstrated that following incidents, risk assessments were updated or put into place to minimise the risk of further incidents occurring.

There were procedures in place for the safe administration of medicines and these were being followed. We looked at three people's records for the administration of their medicines. People received their medicines at the correct time, stock levels were accurate and the form had been initialled and dated as required.

As part of auditing the completion of the medicines administration record sheets (MARs), where there was a gap in a nurse signing the sheet, this was highlighted with a dot and subsequently corrected. This ensured a complete and accurate record of medicine administration. Medicines were stored correctly and safely and records evidenced that stock levels were checked when medicines were delivered. The registered nurse on duty told us that people were involved in making decisions about their medicines, through being given information about the medicine, its side effects and purpose and choosing whether they wanted to take the medicine. No one was given their medicine covertly [without their knowledge].

Plans had been put in place by the provider to ensure that people remained safe in the event of an emergency. In the foyer of the home were comprehensive plans in the event of an evacuation of the premises, with alternative accommodation and transport arranged. The service also had a contingency plan in place to address flood, fire, outbreak of infectious diseases and adverse weather conditions. The home and grounds were well maintained, fit for purpose and safe. The maintenance manager provided us with copies of the home's maintenance plan and risk assessments for the premises, legionella, equipment and essential services. These documents were up to date and complete.

Good

Is the service effective?

Our findings

Six of the eight relatives we spoke with were positive about the care and support people using the service received. One person who was not able to verbalise, gestured by nodding to us that they were 'happy here'. Their relative told us "it is an excellent care home, if [family member] gets distressed the staff know just how to calm her, wonderful food and good caring staff". Health and social care professionals spoke positively about the care and support people using the service received, stating that staff were skilled and caring in their approach.

Care records evidenced that health and social care professionals, such as the mental health team, speech and language therapy and podiatry services were involved in people's care. People were referred to professionals by the staff to assess and review their health needs. Staff told us they provided specific guidance to support the effective delivery of care. We observed one carer who deflected one person's interest away from what was making them agitated, this quickly calmed the person. The information about how to support this person in particular situations was given in the person's care records.

The quality of record keeping was good however; some records had not been fully completed. Of the 11 care records we looked at, two fluid charts were not totalled for the day, a nutrition plan was not in place for one person identified at risk of malnutrition, a monthly inspection of the bedrails had not been dated and a bed rail risk assessment had not been signed. A lack of accurate and complete recording could result in people not receiving the care they required. We discussed this with the registered manager who informed us that their auditing systems had identified improvements were required in this area and would be addressed.

We looked at eleven care plans. Where appropriate, we saw that guidance was available to staff and other professionals on how to most effectively communicate with the person to enable them to express their wishes. Such as, repeating back what the person had asked for, rephrasing the question or allowing more time. In the Lark unit, communication cards with pictures, numbers and words were used by staff to support people to communicate with them.

The design and layout of the building promoted people's independence and privacy. The building was fully wheelchair accessible and a lift was available between floors. The hallways in each of the units were wide and straight which meant that people could walk unsupervised along the hallways if they wished without the risk of knocking themselves on protruding walls. There were chairs dotted around if people wished to sit down. Staff said they 'fully respected people's privacy if they wished to stay in their room with their door closed'.

We saw that staff worked hard to respond to people's needs as quickly as they could. People were offered snacks and drinks throughout the day. Staff sensitively supported people to eat and drink and some people used adaptive cutlery to aid independence. People were given a choice of food and drink. As some people with dementia may have difficulty in remembering their choices, staff showed people the actual plates of food when they asked people what they would like for lunch.

People told us the food was "lovely", "very nice" and "a bit too much for me". One person told us they [the staff] would put their breakfast tray to one side if they had a 'lie in' in the morning. A relative told us they were able to make beverages or snacks in the unit's kitchen if they wanted to. Their family member would help them which they felt encouraged their independence. Care plans documented people's likes and dislikes together with any food allergies or intolerances. We saw that specialised diets were catered for such as, pureed, gluten free, bite size food or vegetarian. A care worker said they monitored people's food and fluid intake where risk of dehydration or malnutrition had been identified. They told us, "we monitor people's weight and notify the nurse in charge if there are significant changes. I recently did this and we are now monitoring this person's food intake. This is now part of their care plan".

Training was available to ensure that staff had the necessary skills and knowledge to be able to support people appropriately and safely. Staff told us they received the mandatory training required by the company, such as safeguarding, infection control, manual handling and health and safety. Training records confirmed this and also provided a list of forthcoming training. Staff undertook training specific to the needs of the people they cared for, such as dementia awareness, diabetes and epilepsy training.

Good

Is the service effective?

One care worker told us the provider was currently rolling out training on managing challenging behaviour. Other care staff told us they welcomed this initiative. To assess how effective the training was, the registered manager told us that they and the heads of units observed staff practice. In addition, training and skill development was discussed during staff supervision. . [Supervision and appraisals are processes which offer support, assurance and develop the knowledge, skills and values of an individual, group or team. The purpose is to help staff to improve the quality of the work they do, to achieve agreed objectives and outcomes.]

The registered manager monitored when staff training had taken place and when it was due to be updated. This ensured that staff kept up to date with best practice. During our visit we found that staff were competent in their knowledge of how to support people. One professional told us "I think staff receive appropriate training for the needs of the resident group".

All of the staff we spoke with received supervision. Annual appraisals for all staff had started in November 2014 with their direct line manager. Nursing staff were supported to maintain their qualifications and develop their professional's skills. Staff told us they were happy with the support and training they received.

New staff undertook a three month probationary period in which they completed an induction linked to the Skills for Care, Common Induction Standards (CIS). CIS are the standards people working in adult social care need to meet before they can safely work unsupervised. The induction included looking at care plans, completing the mandatory training, familiarising themselves with the services policies and procedures and shadowing more experienced staff members.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards is part of the Act. The Dol's provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

All staff received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff recognised their responsibility in ensuring people's human rights were protected. They described how people could be deprived of their liberty and what could be considered as a restraint. Staff told us they did not use any form of restraint. One professional told us "staff have a good understanding of the Mental Capacity Act and Dol's. From the interactions I have witnessed, I would say that staff are respectful, some people can be challenging in their behaviour and some lack capacity, the staff approach is always respectful".

The care plans evidenced that mental capacity assessments had been carried out, particularly for those people who lived in the Lark unit; however there was a lack of detail regarding best interest decisions, such as the steps staff had taken to engage with the person to help them make a decision. We raised with this the registered manager who told us this would be addressed.

Within people's care records we saw that various applications had been made for Dol's, regarding care and support and eating. More recently, the registered manager had applied for a Dol's for people in the Lark unit who were not able to consent to their move into the home. We discussed this with the registered manager as we did not feel the applications fully covered the restrictions placed upon the person's freedom of movement. The Care Quality Commission referred this additional information onto the supervisory body.

Good

Is the service caring?

Our findings

One person told us 'they [the staff] look after me very well' and went on to add "I like [named staff member] looking after me". Another person said "they look after me really well". One person said of the Lark unit "it's really like a family here, we all know each other and look out for each other, the staff are fantastic, couldn't ask for any better".

A relative told us "you can't fault the care as he [my family member] is always clean and never smells and the carers on today are absolutely marvellous".

We saw that staff interactions with people demonstrated genuine affection, care and concern for each individual. One care worker said "we really care about our residents and we do a really good job, we love what we do, it's like a big family, the residents are wonderful".

Staff protected people's dignity by carrying out personal care in the privacy of the person's bedroom. We observed that staff respected people's privacy by knocking on their bedroom door and waiting until being invited in. When staff entered the communal rooms, they acknowledged and spoke with people in a respectful and friendly manner and always using the person's preferred name. Staff joined in with people's jokes and spontaneous sing-alongs.

Staff were mindful of people's emotional wellbeing. In the afternoon, we saw one person had become distressed about 'where they were', the care worker quickly acknowledged the need for support, knelt beside them and offered reassurance. This quickly calmed the person.

In all of the staff interactions with people, staff were friendly, respectful and caring. We observed a care worker supporting a person to eat. This person was receiving palliative care. The care worker sat next to the person's bed and faced the person, giving eye contact and smiling. They were gentle in their manner and encouraged and praised the person as they ate. Staff told us they had received end of life training and additional support from a local hospice called Dorothy House which they had found 'invaluable'. A care worker explained that some people had expressed their wishes for end of life care. They felt that all of the care staff fully respected people's wishes, be it their family around them, spiritual comfort or listening to their favourite music.

The accommodation in the Lark unit was spacious and free from clutter and we saw that people wandered around freely as they wished. A care worker told us "we are always aware of where people are, but it is important to let people have that independence if they want to walk around, go and see other people or take themselves to their bedroom if they wish. One person came into the room where we were sitting. They wanted to know more about what we did [the Care Quality Commission]. We chatted together and they told us "I like living here, although I sometimes get very confused but the staff know me well".

Upon speaking with care staff, we found they were knowledgeable about the people in their care, including what type of work the person used to do, the music they liked, if religion was important to them, their culture and what they believed in. A care worker told us "it's important to get people's life histories, especially as a few people are unable to verbally communicate. When we talk with people about their families, their faces light up".

For the most part, we saw that before staff carried out any personal care or intervention they asked the person's permission and explained what they were about to do. Some people in the home could not verbalise their wishes. Staff told us they knew from the person's body language, sounds they may make or facial expressions, what their wishes were. We saw many good examples of where staff responded in such a way which enabled the person to be involved in making decisions. However, we observed two interactions where the staff member did not ask people's permission before they placed a protective apron on them.

Out of the eleven care plans we looked at, eight care plans had been signed, either by the person themselves to indicate their involvement or by their families or others involved in their care. Three people told us they were involved in reviewing their plan of care and could make changes as they wished.

Where people were not able to participate in their care review, we saw that families were involved, some with a lasting power of attorney [this is where the person would appoint someone they trusted to make decisions of their behalf]. Three care plans had not been signed by a representative, the family or the person themselves. The registered manager told us they would follow this up.

Good

Is the service responsive?

Our findings

During both days of our visit we saw that people took part in various activities. On the first day, people from the Chaffinch and Lark units joined together for a sing song. Some people, who were not able to sing along, used a tambourine to tap to the beat of the music. People enjoyed the session and were well supported by staff to participate. On the afternoon of the second day of our visit, people enjoyed a session from an outside entertainer who played the guitar, sang songs from the 40s and 50s era and told jokes. People from both floors attended this event and there was a lot of laughing and banter from people and staff alike.

Each unit in the home had an activities co-ordinator and details of planned activities were displayed on the information noticeboard. One of the activity co-ordinators told us they had arranged for people to go and see the Christmas lights being turn on in the local town and staff were putting on a Christmas pantomime as part of the festive entertainment. As part of planning the activities, staff consulted with people to find out what interested them and to get ideas for future in-house activities and outings. For people who did not wish to join in with group activities, the activities co-ordinators spent one to one time with people; this reduced the risk of social isolation. Families and other visitors were welcomed to the home. A relative said "I usually come at the same time when I visit but we could visit whenever we want, there is no restriction."

Before people moved into the home, the management team undertook a pre-admission assessment to ensure the home could offer the appropriate support the person required. Care records contained a pre-admission assessment which was completed during a visit to the person by one of the management team. This included reviewing the person's health, emotional and social needs to assess if the home could meet their needs.

Each person had a care plan in place which detailed what support the person required in relation to their health, mobility, social and personal care needs. Care records documented people's preferences in relation to their care and daily living. Families were involved if people could not fully express their preferences. Staff told us that the information given in the care plans enabled them to deliver care in the way the person wanted. We observed many interactions between people and staff which evidenced that staff were knowledgeable about the person's wishes.

Care plans and risk assessments were reviewed monthly or when required to ensure that appropriate care and support was in place. For example, one person who had sustained a number of falls had their risk assessment reviewed and an enhanced falls assessment put into place. A member of staff told us, as the person's keyworker [a keyworker is the main person involved in the person's care], they would be informed of any changes by the nurse or senior care worker who had reviewed the risk assessment. This ensured they had current information on how to support the person safely.

People received support from health and social care professionals such as the mental health team, speech and language and for dental and optical care. We saw evidence in the care records that referrals had been made to professionals when staff had identified a need. For example, one person was seen by the speech and language therapist due to swallowing difficulties. Staff were given guidance on how to prepare food to minimise the risk of choking. During lunch time, we saw the guidance had been followed as the person's food had been cut up into small bite size pieces, which enabled the person to eat independently, they told us "I can manage very well if my food is like this".

Information about the complaints policy was displayed in the foyer and available within the information leaflet about the home. Three people in the Lark unit told us they had no complaints. One person said "Staff listen if we don't like something and quickly deal with it, I've never had to make a complaint but I know how to". We looked at the two complaints which had been raised in 2014. Each had been responded to appropriately in line with the Barchester Healthcare group complaints policy.

We looked at the minutes of a residents meeting held in November 2014 and a relatives meeting in October 2014. This demonstrated that people and their families had the opportunity to put forward ideas and make suggestions for how the service was run. The minutes showed that points from the previous meetings had been followed up.

Good

Is the service well-led?

Our findings

The service had clear values about the quality of service people should receive and how this should be provided. The registered manager said "it's about taking a holistic view of the person and their family, offering a consistent person centred service which is effective and reflects the needs of the person". Staff told us they valued the people they cared for and strived to provide a high quality of care.

The registered manager felt they now had the right climate and culture in the home. They told us "in the last two years, there has been several home managers which has been unsettling for staff. Since I came into post in June 2014, I have spent some time recruiting new staff to fill vacancies. There had been some resistance to the new ways of working and this resulted in those staff leaving". They told us that one of the ways in which they monitored the quality of care people received was through observation of staff practice, and challenging those practices which were out of date or inappropriate. This was also embedded within staff supervision and team meetings. All staff told us they felt supported, either by the registered manager or by their supervisor or line manager.

We spoke with professionals who have regular contact with the home, they said, "I have found the home to be open, transparent and willing to address any recommendations for improving the service" and "the manager is definitely approachable and I have witnessed a very open approach to relatives and people alike". Two-thirds of staff had positive comments to say about the way the home was managed, comments were "there has been a lot of changes with managers, but things have improved." "The manager's door is always open". "It feels so much better now, we've got a lovely manager as well, very approachable". "We get on well, we've got a good team".

One third of staff thought that the manager or the management team were not fully approachable. One care worker said "the manager makes a pot of tea for the residents and staff but never sits and has a chat with us, people would like to get to know her better". Other staff commented that they thought the manager should be more visible and get to know the residents better. There was a mixed review from relatives, one relative said "the current manager has her finger on the pulse" whilst another relative said "we don't see much of her on the floor". We spoke with the manager about this who agreed they had not had the time to spend with people on the floor but would make this a priority.

The registered manager, regional director and heads of departments completed a range of audits of the safety and quality of the service provided. These reviews included assessments of incidents, accidents, complaints, training, staff supervision and medicines. The maintenance manager was responsible for the internal and external maintenance of the home. Checks were carried out on equipment, for legionella, heating and lighting systems and general health and safety. The registered manager met with the regional director on a regular basis to share information and review their delivery plan. They told us they felt supported by the regional manager and "always able to pick up the phone". There was a buddy system in place where the registered manager received peer support from the registered manager of another of the groups' homes, which they found useful.

The service had a development plan in place, which brought together all of the actions needed. One action was to try to involve people in the recruitment process of new staff as a way of ensuring that people were empowered to make decisions about how the home was run. People we spoke with told us they would welcome this involvement.

An annual satisfaction survey was sent out by an independent research agency to people, their families and visitors to the home. The results of the survey informed the planning and development of services. The 2014 survey results were not available to us at the time of our inspection; however the 2013 survey results showed a high level of satisfaction with the service.

The registered manager submitted statutory notifications to the Care Quality Commission as required. They worked in partnership with other organisations to promote best practice in the home, such as jointly working with the Alzheimer's Society in the development of dementia care and with a local hospice, Dorothy House in developing standards of care for end of life. In addition, the home linked in with different community organisations such as the Scouts, schools, local churches, charities and health watch. These services brought the local community into the home and people told us they liked being part of this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use the services were not protected against the risks associated with a lack of adequate staffing levels in which to meet their needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.