Akari Care Limited

Hillfield

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?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 18 and 19 November 2015. It was unannounced.

We last inspected this service in August 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

Hillfield is a care home for older people, some of whom have a dementia-related condition. It provides nursing care. It has 50 beds and had 23 people living there at the time of this inspection.

The service had a registered manager who had been in post for less than a year. 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.

Summary of findings

People told us they felt safe and protected in the home, and said they had no concerns regarding their safety. Risks to people were assessed and managed appropriately, without unnecessarily restricting people's independence.

Staff were fully aware of their responsibilities for safeguarding vulnerable people from abuse. They had been given the training needed to be able to recognise and report any potential abuse. Where there was any suspicion that a person had been harmed, this was reported immediately to the proper authorities.

There were enough staff to allow people's needs to be met promptly and attentively. New staff were carefully vetted to make sure they posed no risk to vulnerable people. Staff received regular training in all the areas required to protect people's health and safety, and to meet their individual needs. People told us staff knew them well and had the skills and knowledge they needed to meet their needs. Staff received the supervision and appraisal they needed to support them in their roles.

People received their medicines from experienced staff who received regular training in the safe administration of medicine. People were assisted to take a nutritious diet. Any special dietary needs were assessed and met. People said they enjoyed their meals. People's healthcare needs were kept under close observation. Appropriate referrals were made to, and advice taken from, other health professionals, where necessary. Feedback from visiting professionals was very positive.

Accidents and other incidents were recorded and analysed to see if lessons could be learned and the environment made safer. People told us they had no complaints, but said the staff would take any concerns seriously and get any concerns resolved.

There were good communication systems in the home. Staff felt listened to by the registered manager and communicated effectively with people to ensure their views were heard and acted upon. People and their relatives praised the staff team for its genuine care and kindness. They said the staff always treated them with respect and affection. Staff demonstrated a positive, individualised approach to people's care, and were proud of their work. People said they were treated with consideration at all times, and their privacy and dignity were protected. They were involved in the assessment of their needs and their views and preferences regarding how their care should be given were taken seriously and incorporated into their care plans. People and their relatives were involved in discussing their care needs and deciding how those needs were to be met. People's care plans were person-centred and personalised.

People said the staff encouraged them to be as independent as possible and make their own decisions about how they lived their lives. If a person lacked the mental capacity to make informed decisions, the service worked jointly with their families and involved professionals to make sure their rights under the Mental Capacity Act 2005 were upheld.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found appropriate policies and procedures were in place and the registered manager was familiar with the processes involved in the application for a DoLS.

The provision of people's social and leisure activities required development. There was no organised programme of activities and people rarely spent any time outside the home.

There was an open and positive atmosphere in the home. People, their relatives and staff all said they were treated with respect by the registered manager. They said they felt listened to and were able to contribute to the development of the service. Systems were in place to monitor the quality of the service and identify where improvements were required.

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?

Good

The service was safe. Staff were fully aware of their responsibility to keep people safe from harm and to report any suspicions of abuse.

There were enough staff to meet people's needs in a safe and timely manner. Risks to people were assessed and carefully managed.

People were given the support they needed to take their medicines safely.

Is the service effective?

Good

The service was effective. Staff had the skills and knowledge they needed to meet people's needs effectively.

Staff were given regular training, supervision and appraisal to support them in their work.

People's rights under the Mental Capacity Act 2005 were understood and respected.

People were assisted to take a nutritious diet.

Is the service caring?

Good

The service was caring. People told us the staff treated them with great care and respect at all times.

People's privacy and dignity were protected.

People were given the information they needed to make decisions about their lives and were encouraged to be as independent as possible.

Is the service responsive?

Requires improvement

The five questions we ask about services and what we found The service was not always responsive. People's need for a varied programme of social activities, with opportunities to enjoy local community facilities, was not fully met.

People said they received individualised care and staff responded quickly to requests or changes in their needs.

People were involved in assessing their needs and deciding how those needs were to be met.

Any concerns or complaints were taken seriously and resolved to the satisfaction of the person.

Is the service well-led?

Good

The service was well led. The home had a very experienced registered manager who provided good leadership.

Summary of findings

There was an open and positive culture in the home, and people's views were respected and acted upon.

Effective systems were in place to monitor the quality of the service.

Hillfield

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 18 and 19 November 2015. The inspection was unannounced.

The inspection team was made up of one adult social care inspector and a specialist nursing care advisor.

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. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities, clinical commissioning groups and Healthwatch to gain their experiences of the service. We received no information of concern from these agencies.

During the inspection we toured the building and talked with 12 people, three relatives/visitors, and two visiting professionals. We spoke with 11 staff, including the registered manager, administrator, nurse, five care assistants, activities co-ordinator, chef, and domestic. We 'pathway tracked' the care of three people, by looking at their care records and talking with them and staff about their care. We carried out a 'short observational tool for inspectors' (SOFI) to gather the experiences of people who could not communicate with us verbally. We reviewed a sample of 10 people's care records; three staff personnel files; and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe and protected by staff. One person said to us, "I feel safe, here, I truly do." Relatives confirmed they felt people were well protected. A relative said, "We have no worries about the safety of the home. I wouldn't sleep if I thought it wasn't safe." A second relative told us, "There's no safety issues here, and it's very clean and tidy."

The service had an appropriate policy and procedure in place for safeguarding people from abuse. This recognised people's right to have police involvement in cases of abuse. Systems were in place for logging safeguarding incidents and details of any investigations, meetings and outcomes. We saw the registered manager reported any safeguarding incidents to the required agencies in a timely manner. Two safeguarding incidents had needed to be raised in the previous year, and both were fully documented. Staff we spoke with told us they received regular safeguarding training and had a full knowledge of their responsibilities regarding recognising and reporting safeguarding incidents. Systems were in place for the regular auditing of any monies held for, or spent on behalf of, people living in the home. Receipts were kept of all transactions.

Staff were able to describe the provider's policy on 'whistle blowing' (exposing bad practice), but said they had not needed to report any such practices in the past year.

All general and specific risks to people were assessed when they were admitted to the home and regularly thereafter. Environmental risk assessments were in place. The registered manager told us each staff member was required to read those risk assessments pertinent to their role(s). To help people maintain autonomy and independence, the service practiced 'responsible risk taking' which allowed people to make informed choices about the levels of risks they might encounter. Staff discussed issues of risk with the person and their family to agree a balanced approach to the risks of daily living.

We saw documentary evidence of regular weekly checks of fire safety systems and firefighting equipment, and there was a monthly fire drill. Checks were also made on the safety of water storage and hot water temperatures in baths and bedrooms. Monthly audits took place of infection control issues, kitchen cleanliness and hand-washing. Files were held documenting such audits, and also the contracts and arrangements in place for the servicing and maintenance of services and equipment in the service. We saw repairs were reported, recorded and resolved in a reasonable time. Control of Substances Hazardous to Health (CoSHH) data sheets were on file and posted in appropriate places to advise staff on chemical product safety. Staff were given personal protective equipment such as disposable gloves and aprons, and good stocks of these were held.

Clear plans were in place for responding to emergency situations such as the failure of service, severe weather or the need to evacuate the building. Each person living in the home had an individual personal evacuation plan on their care file.

The service's accident and incident log was up to date and we saw all accidents were recorded in good detail, even where no injuries had occurred. We pointed out there was no apparent system for analysing accidents, and leaning from such events. The registered manager was aware of this deficit and told us they were introducing a 'trends analysis' record to chart the times, places and individuals involved in accidents to see if steps could be taken to reduce the frequency of accidents. The registered manager was fully aware of the 'duty of candour' owed to people if they were harmed by any mistakes or neglect by the service.

The registered manager told us they used the provider's dependency assessment tool to calculate the staffing levels required to meet people's needs safely. They told us this was used as a guide, and that there was an element of flexibility to allow the manager to vary levels when necessary. The registered manager told us they felt the home was appropriately staffed, and that they would never staff the service at an unsafe level. They told us they would be increasing the staffing levels in line with expected increases in occupancy of the home. Staff we asked told us an extra staff member would be useful, but they were not understaffed. Some concerns were raised about the staffing on the night shift. We asked the registered manager to meet with the night staff to discuss staffing levels. The registered manager reported back to us after the inspection that no concerns had been raised by the night staff.

A robust process was in place to recruit new staff, with the aim of ensuring that only applicants suitable to work with vulnerable people were employed. Appropriate checks, such as with the Disclosure and Barring Service regarding

Good

Is the service safe?

previous convictions and suitability to practice, were undertaken. Applicants' work histories were checked for unexplained gaps, and proof of identity was required. Previous employers were approached for references, and these were verified.

We looked at the management of medicines. Effective systems were in place for the ordering and delivery of prescribed medicines and for the collection of unwanted medicines. Stocks were audited on a regular basis. We saw the medicines trolley was kept locked when the nurse administering medicines was away from it. The medicines trolley was kept secure in a locked room when not in use. We observed a medicines round and looked at the medicines administration records (MARs) for six people.

People's preferences for how they wished to receive their medicines were clearly recorded, as were any allergies the person might have. We found no gaps or omissions in people's MARs.

A protocol was in place for 'as required' medication such as pain killers and laxatives. Records for 'as required' medicines had been properly completed and matched the MARS sheets. We observed that people were asked, during the medicines round, if they needed analgesia. A policy was in place for the covert administration of people's medicines, where the person's GP had given written authorisation for this practice. The storage, recording and auditing of controlled drugs were appropriate.

Good

Is the service effective?

Our findings

People told us their care needs were met effectively and efficiently. One person said, "They are very good. They know what I need and help me in the ways I want." A second person said, "The staff are always there when you need them. You just need to ask and they will do it."

Relatives told us they were happy with the ability of the staff to meet their relatives' needs. One told us, "Staff have the skills and knowledge they need. They deal sensitively with personal issues. It's been a revelation, a God-send, the improvement in my (relative) since they came in here." A second relative told us, "My relative is well looked after. We have never had any complaints." Another relative commented, "Staff have the skills they need." We saw an entry in the service's feedback book that stated, "The GP said our relative's skin was amazing, thanks to the nursing care at Hillfield." Another entry stated, "A very clean, tidy and organised 'home from home'." We noted that 23 of the 26 care staff held National Vocational Qualifications (NVQ) in health and social care or its equivalent.

The registered manager told us that, on their recent appointment, they had been very impressed with the staff team. They said the team was very experienced, highly committed, with a good skills base, and that they were pro-active in their attitude to people's care.

Nursing and care staff demonstrated a good knowledge of people living in the home. They could tell us not only the person's needs, but also about other members of their family, how often people get visitors and the effect of their visitors on them.

New staff members received a comprehensive induction to the home and to their role. This included the satisfactory completion of a detailed induction workbook, which covered the national common induction standards. Examples seen had been completed in a thorough fashion. The registered manager showed us evidence of the planned introduction of the Care Certificate. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. New staff worked supernumerary to the rota for a probationary period until assessed as being competent to carry out their role safely and effectively. New staff were given a staff handbook and induction pack, setting out their responsibilities and rights.

Training records showed staff were kept up to date with the training necessary to keep people safe and meet their needs. A training and development programme was in place. The registered manager told us of the close working partnership the service enjoyed with a local training company which provided fortnightly training courses in the home to keep staff up to date. The registered manager had identified some gaps in the current training matrix and was planning future courses in Parkinson's, dementia care and end of life care. The registered manager told us they encouraged staff to request further training to develop their skills and knowledge. Examples given included advance dementia care, challenging behaviour and fire warden training. Staff confirmed this. One staff member told us, "I asked for first aid training and I got it."

Records showed staff received formal supervision sessions every two months. Issues discussed included individual roles and performance, training needs, care issues and any concerns the staff member might have. The staff appraisal matrix confirmed that appraisal was an annual event, planned in advance.

Staff communicated well as a team. There was a structured handover between shifts, with the nurse giving written and verbal information to the nurse on the incoming shift, who then briefed the care staff. Care staff told us they were kept well informed about changes to people's needs and amendments to care plans. One care assistant said, "We are fully involved. We pass information onto the nurses and tell them if we feel there's been any changes with a person. We are treated with respect by the qualified staff and our views count."

People were assisted to communicate by assessing their needs and offering any appropriate aids or methods for improving communication. For example, one person's communication care plan stated the person agreed to having their television turned off when staff were seeking to talk with them.

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. We saw appropriate assessments had been carried out where there was doubt about a person's capacity to make such decisions.

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 are called the Deprivation of Liberty Safeguards (DoLS). Staff demonstrated a good knowledge of DoLs and the MCA and could describe the reasons for having these in place and the procedure to be followed. Clear records were kept of applications to the local authority for authorisation to deprive individual people of their liberty, in their best interest.

We asked staff how they worked with people whose behaviour could be distressing to them and people around them. Staff told us there were no people currently with such behaviours. They said they had been given good guidance in the past on how to work effectively with people who displayed such behaviour. They told us that specialist advice was sought from the relevant health and social care professionals, including the challenging behaviour team. Advice from professionals was used to draw up care plans specific to the person and their particular behaviours. In general terms they were aware of the need to give a person displaying distressing behaviours space; to ensure the safety of other people in the vicinity; and to apply the approach set down in the care plan. The registered manager told us a third of the care staff group had been given training in this area, and this training had been cascaded to other staff in staff meetings. The registered manager told us further training had been arranged for other staff.

People were asked to give their formal consent to aspects of their care, including personal care, vaccinations, photographs for identification and the administration of medicines. For example, one person had signed their consent for the use of bed rails, to prevent them from falling from their bed. Where a person was unable to sign their consent forms, but was able to give verbal agreement to their care, this was recorded clearly. People we spoke with told us the staff were very good about asking their permission before carrying out any care tasks for them. A relative said, "I have power of attorney and staff always ask my consent before any big decisions or when they want to give personal care."

People's nutritional needs and wishes were assessed on admission using the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. There was evidence of the effective use of food and fluid monitoring charts, with targets set and totals recorded. Any concerns about a person's food and/or

fluid intake were reported to the nurse in charge. We saw evidence of appropriate referrals to specialists such as the speech and language team and dieticians.

We asked people if they enjoyed their meals. They told us they did. We observed a lunch meal, and gave feedback to the registered manager about ways in which the dining experience could be improved. For example, by serving the meal more promptly, so people did not have to sit waiting for unnecessary lengths of time, and not administering people's medicines during the meal. The registered manager told us they were aware of the need for improvements and would make this a priority.

People's physical and mental health needs were considered as part of their initial and ongoing assessments. Routine health checks were arranged as required, including hearing, dental and optical checks. Any significant changes in the person's health were reported immediately to their GP. Clear records were kept of visits to and from health professionals such as GPs, district nurses and chiropodists, and advice given by such professionals was routinely included in the person's care plan. Staff had been trained in the use of the 'national early warning score' (NEWS). NEWS is a system of regularly checking a range of physiological parameters such as pulse, temperature and blood pressure to establish a baseline when a person appears unwell, to inform other involved health professionals, and for monitoring purposes whilst the person is unwell.

We saw each person had a 'body map' completed on admission, to record any marks, bruises, scars, and this was used as a baseline for regular ongoing checks. This enabled staff to spot and report any unusual or concerning marks on the person's body. We saw, in one person's care record,

Good

Is the service effective?

they had spilled a cup of tea on themselves. Documentation showed that appropriate checks had been carried out both immediately and then every hour for 24 hours to ensure the person's continued safety and comfort.

Good

Is the service caring?

Our findings

People told us they were very happy with the staff approach, and said they were kind and caring. One person said, "The staff and nurses are lovely. They do such a good job." A second person told us, "I'm quite satisfied. The carers are gentle and sensitive." A third person commented, "The staff treat me well. I'm new here, and it's better than I expected." Other comments received included, "The staff are very good to me, I like it here. We couldn't ask for anything better."

A relative told us, "All the staff are so friendly, they always make you welcome." A second relative said, "The staff are very attentive and genuinely care, you can tell. They show care and concern for relatives, as well. For example, they told us not to worry about (relative) when we were going off on holiday." Other comments received from relatives included, "Everyone is treated with respect. They are absolutely lovely, the staff"; "This is definitely a caring home"; and, "My relative is happy, here. They get very good care."

We observed a calm, quiet atmosphere in the home, with classical music being played softly in the background. Staff interactions with people were friendly and respectful, and staff had time to engage people in conversations. We observed staff spoke in a caring manner with people and used therapeutic touch during interactions. We saw one staff member speaking to a person who was upset that her relative was late visiting: the staff member reassured the person and offered to ring the relative to check if they were visiting that day. In the opinion of one nurse, "The care assistants give good standards of care and they look after people as if they were their own grandparents". Several people told us they appreciated the fact that there was little turn over in the staff team. One person said, "We get to know them, and they get to know us and our little ways."

People were encouraged to complete their own 'pen picture', giving a detailed description of the person's life and family history prior to them coming to live in the home. Pen pictures included details such as siblings, work, hobbies, friends and relationships, and gave staff knowledge of the whole person. The registered manager told us, and training records confirmed, staff had received training in equality and diversity issues.

Regular monthly meetings were held for people and their relatives. The registered manager told us they actively sought out people's views, both in these meetings and in daily chats with people in the home. Issues raised were resolved and fed back to the next meeting. A book was available in the entrance to the home for people to record their comments.

People and their relatives were given a service user guide on application to the home. This gave them good information about the services available and described the philosophy of care, staff roles, activities, and people's rights.

The service had very recently created a 'Listen and talk' post. The role of this staff member was to be available exclusively to talk with people and their relatives. They had no care duties and the registered manager told us staff had been instructed to ensure no calls were made upon this staff member's that would take them away from this innovative role. We spoke with the listen and talk staff member, who had been in post only a matter of weeks. They told us their role was still evolving, in response to people's expectations, but was essentially one of befriending and listening to whatever the individual wanted to talk about. This might be social chat or sharing any concerns or worries. Part of the role was to develop a holistic knowledge of the person, adding detail to their existing social assessments and life histories. The staff member had requested further training including a diploma in health and social care and a course on reminiscence therapy.

We noted that staff had been given 'dignity in care' training. A member of care staff, who held the additional role of 'dignity champion', gave us examples of how staff protected people's dignity. "We knock on doors and wait; we give choices; close doors when giving care; we don't talk over people and we don't talk about our issues in front of people." This staff member told us they would speak quietly to any member of staff who failed to treat a person with dignity, and remind them of the values in the home. We observed staff were respectful and patient in their dealings with people. They gave them time to think and respond. A relative told us, "They respect people's privacy and dignity here." We saw people's dignity was maintained by being well dressed and well groomed. A relative told us, "(Name) is always dressed in clean clothes and is shaved." A visiting health professional told us staff always ensured

Good

Is the service caring?

the person's privacy when they visited the home to give treatment. They did this by asking professionals to use the privacy of the person's room, or a quiet space, away from other people.

The service user guide described people's right to have maximum independence and live to the fullest potential as being integral to their health and well-being. People told us, and people's care plans confirmed, that they were encouraged to be as independent as possible. There were facilities for married couples to share their accommodation.

The role of advocates was advertised in the entrance lobby. The registered manager told us only one person had required the assistance of an advocate since they took up post. Arrangements had been made for this person, who had no family, to use the services of an Independent Mental Capacity Advocate (IMCA) when deciding if they wished to remain in the home or move closer to their previous abode. IMCA's are independent and objective advocates. They represent people who lack the capacity to make important specific decisions about their lives, such as where they live and about serious medical treatment options, and they have no one else to represent them.

We looked at how the service supported people at the end of their life. The registered manager told us the deputy manager had received training in this area of care, and that further training was being rolled out for all staff. They told us they were considering giving some staff specialist responsibilities in people's end of life care. None of the people in the home were currently in this stage of their lives.

Requires improvement

Is the service responsive?

Our findings

People told us they received person-centred care from staff. One person told us, "My care is negotiated with me." A relative told us, "I was fully involved along with my (relative) in discussions around their care. My (relative)'s care is given in the ways they want. They go out of their way to do things for (relative) and they do anything I ask them, for example, separating their laundry out so I can do it at home."

A full assessment of people's needs was carried out before the person was admitted to the home, to ensure those needs could be fully met. The assessment process included a dependency rating score; assessments of the risks to the person of skin damage, malnutrition and falls; continence and mobility issues; and social and spiritual needs. We saw people's assessments were regularly revisited and updated.

Needs identified in people's assessments were addressed in individual care plans. Most care plan examples seen were detailed, informative and person-centred. They made good use of the information gained in the assessment process and incorporated people's stated preferences about how their care should be delivered. This included any advanced decisions a person may have made, for example, 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) documentation.

Care plans were evaluated at least monthly. However, in two people's care plans we found little evidence of robust re-evaluation of care plans. For example, one person's care plans had been drawn up in 2013 and showed no clear evidence of having been properly reviewed and updated. The registered manager told us they were aware of this and were working through people's care plans to address this issue.

A review was held every six months with the person and their family or other representatives. The review looked at any changes in the person's needs or wishes, and gave the person a chance to comment on their care. A relative told us, "I am always invited to reviews and staff listen to what I say. They ask my views and ask if I have seen any changes."

We looked at the activities and other social stimulation made available to people living in the home. Some areas of need, particularly people's social and spiritual needs, were not fully addressed. We found people's needs in these areas had been assessed, using pen pictures and 'This is my life' documents. We also found staff had a good general knowledge of people's social needs and could give us anecdotal evidence of people being encouraged to pursue their hobbies and interests. However, these needs were not routinely incorporated in specific individual social care plans that would prompt staff action and require regular review.

Staff told us they felt there could be more done to engage with their local community facilities. One staff member told us, "We used to have a mini-bus and used to go on trips to the coast, but people never get out now. We don't have enough staff to do this." A second member of staff felt there was insufficient funding for social activities and trips, and said, "There's some people in here who have never been out."

We spoke with the temporary activities co-ordinator. They told us they were part time, only, and also worked as a care assistant. They said a new permanent activities co-ordinator had been appointed, but they had not yet started. They told us there was no activities programme currently in place, and that daily activities were based on asking people 'What would you like to do today?' Although there was evidence of occasional visiting entertainers, exercise classes and celebrations of special days and festivals, there was no clear pattern of activities. We saw the co-ordinator recorded each person's daily activity (if any) in their individual care file. They accepted this meant they spent almost as much time recording activities as leading them. There were big gaps in people's social activities record. This meant people were not enjoying regular social stimulation, tailored to their individual and group needs and wishes.

We discussed these issues with the registered manager and the regional manager. They accepted there were issues regarding the lack of a structured social activities programme and the lack of opportunities for people to get out of the home and enjoy local community facilities. They told us the appointment of the new 'listen and talk' post was partly in response to this need. They provided us with an action plan to improve social interaction shortly after this inspection. This aimed to facilitate people's better social interaction by enabling trips to local pubs, cinemas, theatres, restaurants and facilities such as the Sea Life Centre. This action plan did not, however, specifically address the issues of resources.

The service user guide promised to empower people to make informed choices about their daily lives and to

Requires improvement

Is the service responsive?

provide people with the information they needed to do this. People we spoke with confirmed to us they were given a good range of choices regarding their daily lives. These included when they rose and retired at night, what they wore, what they ate, where they spent their time and whether to join in activities. A relative commented, "They told (my relative) they could stay in their room, if they wanted, and could choose to have their meals there or in the dining room. My (relative) is given full choice."

The service's complaints policy and procedure was clearly displayed in the entrance lobby, and was referred to in the 'service user guide' and the home's brochure. The registered manager told us people were encouraged to raise any concerns they might have in the monthly meetings held for people and their family members.

A complaints book was kept. We saw two complaints had been logged in the previous year. Both had been recorded in good detail, with evidence of proper investigation of the concerns and clear outcomes, including the complainant's degree of satisfaction with the outcome. Appropriate actions were taken in response to complaints, for example, the raising of a safeguarding alert and the retraining of staff members.

Arrangements were in place to aid the consistency of a person's care when they transitioned between services. These included detailed discharge/transfer letters and copies of all relevant care records.

Good

Is the service well-led?

Our findings

People told us they were very satisfied with the way the home was managed. One person told us, "I've seen changes for the better since the new manager came. They have a better sense of proportion and more people-centred." Relatives also spoke highly of the registered manager. One relative told us, "The manager is really nice. Has an open door, really puts themselves out, and is the top manager over recent years. The home has picked up dramatically, its better organised, cleaner and I couldn't pick any faults with the home."

We spoke with two visiting health professionals. They told us the service was well-managed and well-organised, and that they had no concerns regarding the quality of people's care. One told us, "We never have any problems with this home."

We found a culture of inclusiveness and transparency in the service. The manager operated an 'open door' policy. Communication between people living in the home, staff and management was open and honest and demonstrated mutual respect. Staff felt able to raise issues with the registered manager, they had the confidence to challenge current practice, where necessary, and suggest changes. Monthly meetings were held with people and their relatives, and with the staff team. Minutes of meetings showed that issues raised were addressed, and the outcomes fed back to the next meeting. The registered manager told us they had a vision of a service that provided outstanding care and said they wanted to strengthen the voices of people and staff in shaping this vision.

Staff were appreciative of the registered manager's approach to them and to people in the home.

One staff member told us, "We get clear and strong leadership. The manager will challenge any poor practice but does it in a positive way, and has the respect of the staff team. The home is developing again." A second staff member said, "The manager is good – deals with things efficiently, clear in what's wanted, and supportive of staff. The deputy manager is great, as well." A third commented, "I'm very happy with how the home is managed." Another staff member commented, "The manager models good values."

Staff took an obvious pride in the quality of the service they provided and their team work. One staff member said, "Everything runs smoothly – we've got a good team." Another staff member told us, "I think the care we give is brilliant. We always work together and it shows in how long the staff team has been together."

The registered manager was fully aware of the 'Duty of Candour', introduced under recent legislation. They told us they understood this to mean "Being honest and open with people about anything that goes wrong in the home and reporting it to the appropriate authorities."

The service had systems in place for monitoring the quality of the service provided. The registered manager and/or designated senior staff conducted monthly audits of areas such as medicines, infection control, staff hand washing and kitchen cleanliness. The registered manager submitted a monthly quality monitoring report to their regional manager on issues including occupancy, accidents, complaints and safeguarding issues. The provider had a specialist quality team that carried out periodic quality assessment visits. Issues identified as requiring improvement were included in the service's home development plan, and monitored closely by the regional manager, who also conducted their own audits. We saw the home development plan was an active document. When we queried why some issues of concern picked up in a recent audit were not on the development plan, the registered manager gave us evidence to prove they had already been actioned.

The registered manager told us the home was keen to foster links with its local community. It had visits from local schoolchildren at Christmas and harvest festival. Local Anglican and Catholic priests visited the home regularly. The service held occasional 'open days' to which local people were invited. The service also encouraged the use of suitably vetted volunteers.