Care Quality Commission

Countrywide Care Homes (2) Limited

Barnes Court Care Home

Inspection report

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Ratings

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

Overall summary

Barnes Court Care Home is a purpose-built home with three floors. It provides care for people with complex physical and neurological needs on the ground floor, dementia care on the first floor and nursing care on the second floor. It is situated in a residential area with good access to local shops and community amenities. The home is registered for 89 places but only 66 places were available across the three units because the home no longer uses shared rooms. At the time of this inspection there were 51 people living at the home.

This inspection took place over two days. The first visit on 1 October 2014 was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 8 October 2014 to speak with the manager as she was unavailable on the first visit.

The last inspection of this home was carried out on 30 July 2013. The service met the regulations we inspected against at that time.

There was a registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were positive about the service they received. People and their relatives felt the care service was safe. People felt they received attention in a timely way and that there were enough staff to meet their needs.

Staff were clear about how to recognise and report any suspicions of abuse. Staff told us they were confident that any concerns would be listened to and investigated to make sure people were protected. The provider made sure only suitable staff were employed. People were assisted with their medicines in the right way. The small number of people who looked after their own medicines were helped to do this in a safe way that promoted their independence.

People felt the standard of accommodation on the ground floor was good, but the second floor accommodation was in need of redecoration. The provider agreed this was an area that needed to be improved and had plans to do this in 2015.

People and visitors had confidence in the skills of staff to meet people's needs. Staff had the relevant training and support to care for people in the right way. Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision. People's safety was protected without compromising their rights to lead an independent lifestyle.

People's health care needs were continually assessed, and their care was planned and delivered in a way that met their individual needs. Staff were knowledgeable about people's individual care needs and how they wanted to be assisted. People said any changes in their health needs were referred to the relevant health care services. Health care professionals said the home responded quickly to any changes in people's well-being.

People were supported to eat and drink enough and they had choices about their meals. People and relatives felt staff were caring and kind. People were encouraged to make their own decisions and choices in a way that was meaningful to them. Staff understood what was important to each person and were familiar with their preferences. There was a sociable atmosphere in the home and there were warm and friendly interactions between people and staff. People had opportunities to join in activities or go out with staff from time to time. There were plans for this to be improved with new activity staff.

People were asked for their views about the home and these were used to improve the service. People had information about how to make a complaint or comment and these were acted upon. People, family members and staff felt they could approach the manager at any time and said she was "helpful" and "supportive". The provider had an effective system for checking the quality and safety 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?

Good

The service was safe. People felt safe at the home and with the staff who supported them. Staff knew how to report any concerns about the safety and welfare of people who lived there.

Risks to people were managed in a safe way so that people could lead as independent a lifestyle as possible.

There were enough staff to meet people's needs. The provider made sure only suitable staff were recruited. People's medicines were managed in the right way.

Is the service effective?

Requires Improvement

The service was not always effective. People felt the standard of decoration and design of the accommodation was good quality in some areas but not in others. The provider agreed and said there were plans to redecorate the first and second floor accommodation in the next six months.

People felt the service met their individual needs and that staff were well trained. Some people had complex needs and staff said they had good opportunities for training in those specific health needs. Staff understood how to apply Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily, unless it was in their best interests.

People said the food was good quality and they had plenty of choices. People were assisted to have a good diet and plenty of drinks to help them stay as healthy as possible. People were helped to access other health care services whenever this was required, and the home staff worked well with those services.

Is the service caring?

Good

The service was caring. People said staff were caring and friendly.

People said the staff knew their individual preferences and helped them to make choices in a way that suited them. Staff were reassuring, polite and supportive when talking to people.

People and family members said staff were respectful. Staff helped people in a way that preserved their dignity.

Is the service responsive?

Good

The service was responsive. People and family members said staff understood what was important to each person as an individual and how they liked to be assisted.

Summary of findings

People felt there were some activities and opportunities to go out. A heath care professional felt there could be more activities in some units, and the home had plans to do this when new activity staff members were in post. There was good access for people to go into the garden or outside.

People and their relatives said they would be comfortable about making a complaint if necessary. They had confidence in the manager to look into any concerns. There had been no complaints about the home in the last year.

Is the service well-led?

Good

The service was well-led. People and family members felt the home was well managed. They felt the manager was approachable and always available.

People were encouraged to make comments and suggestions about the running of the home. Staff said they felt well supported by the manager and senior staff, and felt valued by the provider.

People's safety was monitored and the provider had effective systems for checking the quality of the care service.

Barnes Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 October 2014 and was unannounced. The inspection team consisted of three adult social care inspectors. A second visit was made by one inspector on 8 October 2014 which was announced.

We spoke with 17 people living at the home and seven relatives. We also spoke with the registered manager, three nurses, eight care workers and a cook. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of eight people, the recruitment records of four staff members, training records and quality monitoring reports.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We joined people for a lunchtime meal in the dining rooms on each of the three units to help us understand how well people were cared for.

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. Before our inspection, we reviewed the information included in the PIR along with other information about any incidents we held about the home. We contacted the commissioners of the service and the local Healthwatch group to obtain their views. (Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.)

During and after the inspection we asked a range of health and social care professionals for their views about the service provided at this home. These included a senior social worker, a nurse assessor, a dietitian and a social worker from the challenging behaviour team.

Good

Is the service safe?

Our findings

People said they felt "safe" at the home and with the staff who supported them. One person told us, "It's a really nice home, and the staff are really friendly." Visiting family members told us they had "no concerns" about the safety of the service. One family member told us, "It feels really safe. My relative always seems happy and comfortable." Another family member commented, "My relative took a while to settle but I know he is safe here." The health and social care professionals we spoke with told us the service managed people's needs in a safe way that took account of their individual needs and also the well-being of others around them.

Staff had a good understanding of how to respond to safeguarding concerns. All the staff we spoke with said they would not hesitate to report any allegations or incidents of abuse. Staff were able to describe the different signs of abuse and knew how to raise any concerns immediately. The manager had notified the local authority, and CQC, of any safeguarding incidents and had taken appropriate action to protect people.

Staff told us, and records confirmed, they received training in safeguarding vulnerable adults. All staff, including ancillary staff, had access to on-line training in safeguarding adults which they were required to complete at least annually. This was checked and discussed at their regular supervision sessions with their line supervisors. The training records showed that 98% of staff had completed safeguarding adults training within the past year. The remaining member of staff was due to complete it the week of our inspection.

Risks to people's safety and health were appropriately assessed, managed and reviewed. People told us, and records showed, they had been involved in making decisions about acceptable risks to their safety, wherever their capabilities allowed, such as managing their own medication or going out independently.

There were risk assessments about people's potential for falls, pressure damage to their skin and using moving and assisting equipment. The assessments included management plans about how to reduce the potential risks to the person. These records were personalised for each person, up to date and were reviewed monthly or more often if people's needs changed. The manager also kept a 'residents at risk' report to make sure any specific risks to individual people were monitored and referrals to relevant health agencies, such as the falls clinic, were made if necessary.

People, relatives and health care professionals felt there were enough staff to support the people who lived at the home. One person on the ground floor told us, "There's always plenty staff on the floor." A family member visiting the first floor told us, "There are plenty of staff, and it's always familiar faces which is really important." There were three separate units in the home. The ground floor and part of the first floor provided a unit for up to 25 people who had physical disabilities or illnesses. There was a registered nurse and three care workers supporting 14 of the 15 people using this service, and another care worker provided one-to-one support for one person for 12 hours a day.

The remainder of the first floor provided a 16 place unit for older people with dementia care needs.

On this unit there were a registered mental nurse and two care workers to support 14 of the 15 people using this service, and another care worker provided one-to one support for one person for 12 hours a day. One staff told us, "We're kept busy but there's plenty of time to interact with people, so we're not rushing them." On the second floor nursing unit there was a registered nurse and four care workers to support the 21 people who lived there. One staff member commented, "It's safe though busy."

There were enough staff to meet people's needs. Staff were engaged with people throughout our visit and responded quickly to people's requests for support, for example help to go to the toilet or to go to their room. A visiting health care assessor told us, "There seem to be plenty of staff about to ask anything." Another care professional from the challenging behaviour team commented, "There's always a member of staff in the lounge to assist people. It's a static staff team so staff get to know people's needs well and are able to discuss them with us."

The home had a low turnover of care staff and ancillary staff. At this time there was one vacancy for a nurse and these hours were covered by existing nurses and the registered manager. The registered manager explained that she preferred not to use agency staff unless it was critically necessary. This was because existing staff were familiar with people's needs and would be aware of any changes in

Good

Is the service safe?

their well-being. We looked at recruitment records for four staff members and spoke with staff about their recruitment experiences. We found that recruitment practices were thorough and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the home had checks in place to make sure that staff were suitable to work with vulnerable people.

The arrangements for managing people's medicines were safe. Medicines were securely stored in locked treatment rooms on each floor. Only the nurses on duty held the keys for the treatment rooms. Medicines were transported to people in locked trolleys when they were needed. Staff gave people the support and time they needed when taking their medicines.

People told us the staff provided them with the right support with their medicines. One person said, "I have memory problems, so it's best for staff to look after my medication as I wouldn't remember if I had taken it." They confirmed they got their medicines at the right time.

Those people who had chosen, and been assessed as able, to manage their own medicines were provided with secure storage in their bedrooms. One person told us, "I've got a key to my medicines cupboard and I keep it locked. The staff count the tablets every now and again to make sure I'm taking them." One person's prescribed creams which they self-administered had not been recorded on their medication administration records, and some prescribed creams were in the wrong people's rooms. We told the manager about this and it was addressed immediately.

The provider made sure nurses were trained and competent in supporting people with their medicines. Training records showed that nurses had received updated training in administering medicines by an external training agency in March 2014. There were records of checks of their competency to do this which had been carried out by a pharmacist.

Records about the administration of medicines (MARs) were accurate and up to date. Each person was clearly identifiable on their MARs and any known allergies were recorded on the front of their medication chart. Medicines that were not needed were disposed of safely.

Requires Improvement

Is the service effective?

Our findings

People told us staff understood their needs and supported them in the right way. Some people had very complex needs and they felt staff had the skills to meet those needs. People described the care service they received as “very good”. One family member told us, “My relative has a keyworker who knows him very well and he knows her. She understands he uses gestures as communication, like when he pulls his shirt it means he wants to go to his room.” During discussions with another person, who had communication needs, a care worker brought the person a notebook they often used, so they could write their comments down for us.

People and relatives felt staff were well-trained. One visitor told us, “Staff always seem to get plenty of training.” Another relative commented, “Staff are competent and confident in their roles.”

Staff told us, and records confirmed, they received necessary training in health and safety matters, such as first aid, fire safety, food hygiene and infection control. Some staff were trainers in moving and assisting so they could provide training to all staff members whenever this was needed. This was important because many people required support with moving and mobility equipment. Staff also spoke enthusiastically about specific training they received or had requested to help them understand the specific needs of people who lived there, for example in Huntington's disease. Care workers also described further training in dementia care they were about to start.

New members of staff told us, and records confirmed, they had completed a thorough induction programme which covered all necessary training before they started to work on the units. New members of staff completed a three month probationary period. New staff and any agency staff members worked alongside and were supported by experienced nurses and care workers. Staff told us, and records confirmed, they were allocated a line supervisor who planned two monthly supervision sessions with them. All staff also had an annual appraisal with the manager. The staff we spoke with said they felt supported to carry out their role. One newer member of staff told us, “As a new starter I’ve been very supported and feel comfortable about asking anything.”

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The manager was aware of the recent supreme court decision about DoLS to make sure people were not restricted unnecessarily, unless it was in their best interests. She had made DoLS applications to the local authority in respect of people who needed supervision and support at all times. At the time of this inspection nine DoLS applications had been sent to local authority for authorisation. This meant the home was working collaboratively with the local authority to ensure people’s best interests were protected without compromising their rights.

The manager and staff were clear about the principles of the Mental Capacity Act 2005. There were detailed assessment records about the capacity of individual people to make their own decisions, and records of best interest meetings where they did not have capacity to do this. The home had involved independent advocates appointed by the local authority where people did not have representation at best interest decision meetings.

People were very complimentary about the quality and choices of meals. One person told us, "You can have anything you want. If there’s nothing on the menu you want, you make a request to the kitchen and they will knock it up for you.” This person had asked for something different from the menu choices and this was arranged by the cook. A family member commented, “The meals are amazing. They’re well fed and constantly being offered food.”

We joined people for a lunchtime meal in the dining rooms on each of the three units. There were menus on the tables for people to choose from. People were asked for their preferences before the meal so they could make an informed and timely choice. The meal arrived promptly so people did not have to wait. During the meal care workers were supportive and engaged with people, encouraging them to enjoy their meal and offering them visual alternatives if necessary. For example, one person was being assisted at their own pace. The care worker constantly described the meal and offered them additional foods and drinks if they seemed disinterested. The cook

Is the service effective?

and care workers were able to describe the known likes and dislikes of people but always offered them choices, such as brown or white toast and a variety of cold and hot drinks.

A dietitian told us, "Staff adapt their usual practice to meet the needs of residents, for example one person was always distracted at mealtimes therefore they try to offer her food in her room or when the dining room is quieter." They also told us staff were timely in identifying people who required input from dietitian services, and that staff always had the required information to hand about people when they visited to carry out assessments. The dietitian told us staff were proactive in encouraging fortified diets for people who required additional nutritional support. For example, offering enriched milk, homemade fresh milkshakes, plenty of puddings and snacks.

The cook was motivated and enthusiastic in her role. She had worked at the home for some years and was very knowledgeable about each person's individual preferences, as well as their specific dietary needs. People got the individual support they needed to enjoy their meals. For example, one younger person was assisted with their meals and drinks throughout the day in a sensitive, dignified way. Their drinks were provided in a lidded beaker with a straw to help them to drink. A family member described how their relative was provided with a pureed diet that was made to look as appetising and attractive as possible. They told us, "They always make sure each part of the meal is prepared so it looks like a proper meal."

We saw nutritional assessments for people who needed support with their diet. We also saw records of referrals to dietitians and speech and language therapists and their guidance was recorded in people's care plans. This had been effective because some people had been able to stop using nutritional supplements as their weight and well-being had improved.

People told us they were supported with health care needs at the home. One person said, "They are very good. They've brought me back to life twice." People also felt the home contacted other health care specialists whenever this was necessary. One family member commented, "My relative has only become chair bound recently and they made immediate arrangements for a chair specialist to come out."

The health care professionals we spoke with confirmed that the home staff made appropriate and timely referrals. For example a senior social worker involved with one person who had complex needs told us, "Staff have involved all relevant professionals to support the resident in an attempt to meet their emotional and psychological needs as well as their physical needs."

There were no hazards within the home's premises that would present a risk to the people who lived, visited or worked in the home. However, there was a distinct difference between the quality of decoration to the accommodation on each of the three floors. The ground floor accommodation was bright, well decorated and people were pleased with their rooms. One person told us, "It's nice. They're doing it all up. The bedrooms are gorgeous."

On the first floor there were plans in progress to redecorate the accommodation. Various colour patches had been painted on the walls for people, visitors and staff to choose their preferred colour scheme for the communal areas. There was some signposting to help people find their way around this unit including open dining room doors and murals on walls. However the unit was not specifically adapted to support people with dementia. For example, all bedroom doors were the same colour, bathrooms and toilets were not easily identifiable, and several clocks displayed different times which could be confusing.

There were areas on second floor unit that were not in good decorative order. For example, handrails and skirting boards were chipped; bedroom doors were marked due to damage caused by wheelchairs and trollies; bathrooms were bare; and corridor walls were scuffed. The carpet in the second floor corridor was discoloured in places, although staff told us it had only been laid less than two years ago. One visitor to the second floor unit commented, "Second floor, second class."

The regional director acknowledged that recent improvements had been made to the ground floor accommodation and new decoration was now in progress for the first floor. He told us, and confirmed in writing, there were also plans in place for the second floor to be decorated in 2015 which would address these shortfalls in decoration.

Good

Is the service caring?

Our findings

People told us the staff were “friendly” and “lovely”. People said they “liked” the staff. One person said, "I get on great with everyone. It's really nice in here, staff are really friendly.” One family member told us, “The staff are very caring. They can’t do enough for my relative, and they’re lovely with them.” Another family member commented, “The staff are very respectful, my relative is treated as a person not just as another resident.”

People told us they had very good relationships with staff. There was a convivial, sociable atmosphere in the home. People and staff spent time chatting and joking. People were visibly relaxed and comfortable with all staff, including catering, housekeeping staff and maintenance staff. A family member told us, “The staff really interact with them. They always talk with them, even though some people can’t talk back.”

Some people introduced staff members as their ‘keyworker’ and described how staff helped them to lead the lifestyle they wanted. One person told us, “My keyworker is there just when I need him. He's a lovely lad." Another person told us, “All the staff are very polite and helpful.”

People who were able to express a view told us they made their own choices about their daily lifestyle. For example, one person commented they were “free to come and go” and “it’s my choice”. This person had a bus pass and if they were going out they told staff who then provided them with a mobile phone so they could ring if they needed assistance whilst they were out.

People told us they made choices about their own daily routines, such as getting up and going to bed. One person said, "I don't sleep well, so I go to bed about 3 or 4am, then I have a lie in. No-one disturbs me." One person preferred to stay in their room most of the time and this was respected.

Some people, who could not express their choices verbally, had care plans about how staff could offer them choices in other ways. For example, one person’s care ‘choices’ care plan stated, “Encourage her to choose when to rise and retire, what clothes to wear, her meals, drinks and activities.”

Family members told us staff treated people in a respectful and dignified way. One family member commented, “Whenever we come he always looks well cared for, clean and shaven. They look after people’s dignity, and they change people’s clothes even if they just have the slightest mark on them.”

Staff were able to describe how they made sure people’s privacy and dignity was respected when they were being supported. For example, making sure bathroom doors were locked when in use, closing curtains when people were getting changed, and covering people with towels to protect their dignity when they were being supported with personal care.

Staff spoke with people in a reassuring way when they were about to assist them, for example with mobility equipment or personal hygiene. Staff were respectful of people’s choices whilst also supporting them with their appearance and dignity. For example, a care worker gently asked one person, whose dementia needs meant they could be resistive to any physical assistance, if they would like support to have a shave. The person declined and the care worker respected this decision and spent time with them chatting about the person’s work-life when they were younger. Later the staff member gently asked again if the person would like a hand to have a shave and the person happily accepted.

In discussions staff members commented on the discreet and polite manner that all staff adopted when supporting people. One new member of staff commented, “Everyone I’ve worked with likes to make sure people are looked after well. They talk nicely to people and they do what people ask them to do.”

Good

Is the service responsive?

Our findings

People told us they were involved in decisions about their care, if they wanted to be. Some people said they had been asked but didn't want to be involved. Other people would not be able to be involved due to their limited capacity. People's care records included a section called 'participation in care planning' which showed how and whether each person had been able to be involved in their own care planning. A social worker told us, "The manager and nurse in charge of the unit have had regular meetings with [the person] and their family to make sure that [the person] is included in all decisions about their care."

People had care plans that set out their individual needs and how they required assistance. In the eight care records we looked at it was clear that people's individual needs had been thoroughly assessed before they moved to the home. The assessments showed what people could manage to do independently as well as the areas of care each person needed support with. The assessments were used to design plans of care for people's individual daily needs such as mobility, personal hygiene, nutrition and health needs. The care plans were detailed and provided guidance for staff about how to support each person with their specific needs. A visiting health care assessor told us, "The care plans are really clear. They really show the person and what they need. It meant I knew the person's needs before I met them."

Care records were written in a sensitive and valuing way that promoted people's abilities. For example, one person's care plan about eating and drinking said, "[Name] uses a spoon or fork or fingers to eat their meals. They like to drink tea with one sugar, juice, milk, sherry and wine." The care files included information about what was important to each person. These included people's individual spiritual wishes and personal preferences such as what name they preferred. There were also booklets with essential and personalised information about each person that could be taken with a person if they needed to transfer urgently to another care service, such as hospital.

A social worker who was involved in the placement of a person staying in the dementia unit told us the manager and staff were "proactive" and "responsive to [people's] changing moods and needs". Another health care professional commented, "The staff respond to changes in people's needs and get in touch quickly." Other comments from health care professionals included "Staff work really well with social workers and other care professionals", "information is shared amongst the relevant staff and professionals" and "staff are engaged and responsive to guidance from care professionals".

People and family members told us there were activities provided in the home. There was a games room on the ground floor unit where some people enjoyed playing computer games. There was also a craft room on the second floor with a bar and tables for people to engage in art and crafts or games, although this was not widely used at the time of this inspection. Care workers on the ground floor spent time with people engaging in individual activities such as games and jigsaws or supporting people to go outside. On the first and second floor there were occasional impromptu activities provided by care workers, such as dominoes, music and soft ball games. One visitor commented, "[My relative] doesn't take part in activities because of his poor health. But staff come and hold his hand and they put classical music on in the background because they know he likes this."

One health professional told us people on the first floor would benefit from more structured activities and a quiet lounge as an alternative to the main lounge which could become noisy at times. At the time of this inspection the 'activities' post was vacant but two care workers had recently been appointed to job share this role in the near future. Some people described how they enjoyed going out of the home with staff support. One person felt there were not sufficient opportunities to go out at this time because the home's minibus was broken. The manager confirmed the bus was awaiting repair.

Some people on the first floor told us they enjoyed spending time in the garden area in better weather. There was good access to the garden from the first floor lounge and it was secure and well maintained with plenty of garden furniture. People on the ground floor were also assisted, whenever they requested, to go outside to a smoking area. The manager described future plans to provide a sheltered area outside for people to use.

People said they would feel comfortable about making comments or complaints. People said they could discuss anything with care staff but would make a complaint to the manager if necessary, and were confident she would act

Good

Is the service responsive?

upon any concerns. One person told us, “I would go to the manager and see her or the regional manager. I see him once a week. He is very polite. If I had a problem, I could go and see him. He's fair."

There was a leaflet stand in the reception area of the home that included information for people about how to make a complaint, how to access other services and advocates, and the home’s statement of purpose. None of the people we spoke with had made any complaints about the service. One relative described how the manager had helped them when they wanted to make a complaint about another care service and they had appreciated this support. A visiting relative told us, “I’ve had no complaints but I’m confident they would be listened to.”

A monthly complaints report was forwarded to the provider’s quality assurance team so that any issues could be dealt with appropriately and any lessons learnt could be incorporated into improving practice at the home. There had been no complaints received in the past year.

Good

Is the service well-led?

Our findings

There was a registered manager at the home who had been in post for just over a year. People and family members commented positively on the way the home was run. People told us the manager had a visible presence in the home and they often spoke with her. They told us she was "approachable" and "helpful". A visitor commented, "The manager has made huge improvements since she's been here."

Staff also told us the manager was approachable and accessible. One staff member told us, "I could go to her at any time. She always comes onto each unit every morning to say hello to everyone. Her door is always open and I feel I can pop in and discuss anything with her."

The provider asked people for their views of the service as part of its quality assurance process. People and family members felt there were good opportunities for them to comment on the service and make suggestions for improvement. One person told us, "The manager is always asking us if anything could be improved." The manager described the bi-monthly residents' and relatives' meetings where people were invited to provide feedback on the service. These had not always been well-attended so the manager had asked people if they would prefer informal social occasions, such as coffee mornings, to encourage them to make their comments.

The provider also had arrangements with an external organisation to carry out an impartial annual survey with people who lived at the home, called 'Your Care' rating. At the time of this inspection the results for 2014 had not yet been collated, but would be made available in the home and on the website. In this way the manager and provider actively promoted feedback from people who used or visited the service.

Staff also told us they were encouraged to make suggestions and that these were acted upon. One staff member commented, "The manager listens and tries to change things for you. For example, a range of staff used to provide the 12 hour one-to-one support for a person. Staff thought the person would benefit from a smaller team of staff so two care workers volunteered and it was agreed. The person's behaviour has now improved a great deal."

All the staff we spoke with were aware of the provider's whistle-blowing policy, and were clear about their responsibility to report any poor practices. Some staff described an issue they had raised with the manager about the practices of a colleague. A meeting had been held with the staff group and arrangements had been made for staff to work in pairs so they could learn the standards expected of them. Staff felt this situation had been sensitively handled and had led to improvements in practices.

The provider's values and principles of care were explained to staff through their induction training and there was a positive culture in the home. Care staff described the manager and senior staff as "respectful" and "supportive". The manager worked alongside staff on some shifts which allowed her to observe the care provided and to check that the home's values were put into practice. The manager and quality assurance manager also carried out 'walkarounds' to check this.

All the staff we spoke felt valued by the manager and the organisation. The provider was looking at ways to attract and retain more nurses. The provider had appointed a Head of Nursing to look at how this might be achieved and to support nurses with their continuing professional development. The provider had reward schemes for its staff members including vouchers towards health care services such as opticians and physiotherapy.

There were regular meetings between staff at all levels of the organisation. Staff felt there was clear and consistent direction from seniors and management within the home. One staff member commented, "The manager keeps us up to date with any changes and keeps us informed and involved." The provider's human resources manager carried out annual surveys to gather the views of staff who worked at the home. The human resources manager also visited the home on a two monthly basis to offer confidential meetings for staff members.

The provider had a quality assurance programme which included monthly visits by a quality assurance manager to check the quality of the service. We saw detailed reports of these visits and action plans and timescales for any areas for improvements. We saw the quality assurance manager checked that any actions had been completed at the next visit. In this way the quality assurance system was effective because it continuously identified and promoted any areas for improvement.

Reports of any accidents and incidents were overseen by the manager and were sent to the quality assurance

Good

Is the service well-led?

manager each month. These reports were analysed for any trends and checked to make sure action had been taken, such as referrals to appropriate health services. For example, recent accident reports showed four people had been "found on the floor" without injury but this indicated they required additional support at certain times. As a result the manager had arranged for floor sensors to be fitted in their bedrooms so that staff could be alerted immediately if a person was out of bed. In this way the manager and provider ensured that monitoring systems were effective in identifying and minimising the risk of further incidents.

The home was subject to monitoring by other agencies, including commissioners. At the most recent audit by the Clinical Commissioning Group (CCG) in August 2014 the home had achieved an overall score of 96.5%. The audit was based on standards that included nutrition and hydration, pressure care, falls, dementia care and supervision and leadership. The clinical quality officer of the CCG told us that the manager "demonstrated good leadership skills".

The provider had memberships with other organisations to make sure its service was up to date with national best practice standards. These included Dignity in Care, Action on Elder Abuse, Social Care Institute for Excellence and the National Association for Providers of Activities for Older People (NAPA). (NAPA is a registered charity for all those interested in increasing activity opportunities for older people in care settings.) This helped to make sure the home was up to date with national best practice standards.