Exmouth Care Ltd

Linksway

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 9 and 11 August 2016. Linksway is a nursing home providing personal care to a maximum of 24 people. The home is a detached house located in the coastal town of Exmouth in East Devon. On the first day of the inspection there were 17 people staying at the service.

There was a registered manager 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 2008 and associated Regulations about how the service is run.

Everyone was positive about the registered manager and the management team and felt they were approachable and caring. The registered manager was very visible at the service. The provider and registered manager demonstrated they had a clear vision and values for the service.

There were sufficient and suitable staff to keep people safe and meet their needs. The staff and registered manager undertook additional shifts when necessary and agency staff had been used to ensure adequate staffing levels were maintained.

The registered manager and staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments had been completed and best interest decisions made in line with the MCA.

People were supported by staff who had the required recruitment checks in place. Staff had received a full induction and were knowledgeable about the signs of abuse and how to report concerns. Staff had the skills and knowledge to meet people's needs.

People were supported to eat and drink enough and maintain a balanced diet.

People said staff treated them with dignity and respect at all times in a caring and compassionate way. People received their prescribed medicines on time and in a safe way.

A designated enabling person was in the process of being employed by the provider to support people so they did not become socially isolated.

Risk assessments were undertaken for people to ensure their health needs were identified. Care plans reflected people's needs and gave staff clear guidance about how to support them safely. They were personalised and people had been involved in their development. People were involved in making decisions and planning their own care on a day to day basis. They were referred promptly to health care services when required and received on-going healthcare support.

The provider had a quality monitoring system at the service. The provider actively sought the views of people and staff. There was a complaints procedure in place and the registered manager was aware of how to respond to complaints appropriately.

The premises and equipment were managed to keep people safe.

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 said they felt safe. Staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised.

People's risks were managed well to ensure their safety.

There were effective recruitment and selection processes in place.

People's medicines were safely managed.

The premises and equipment were well managed to keep people safe.

Is the service effective?

Good

The service was effective.

Staff received training and supervision which enabled them to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well. Nurses dealt with the day to day nursing needs of people. However they ensured referrals were made to health and social care professionals when necessary and followed advice they received.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, relatives and health and social care professionals were consulted and involved in decision making about people in their best interests.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People were supported by staff who were friendly, caring and respectful.

Staff respected people's privacy and supported their dignity.

Positive feedback was received from professionals and people living at the home about the standard of end of life care provided.

Is the service responsive?

Good

The service was responsive to people's needs.

People's needs were assessed. Care plans were developed to meet those needs.

People had been involved in planning their care. Care records were written in a personalised way.

Staff undertook activities at the home as able. A designated enabling person was being employed to support people so they did not become socially isolated.

There were procedures for people, and those that matter to them, to raise issues, concerns and compliments

Is the service well-led?

Good

The service was well led.

Everyone spoke positively about the service and how well the registered manager, nurses and staff worked with them.

People, their relatives, staff and health professional's views and suggestions were taken into account to improve the service.

Incidents and accidents had been analysed to see if there were patterns or themes which could be avoided or needed to be addressed.

There were effective methods used to assess the quality and safety of the service people received.

Linksway

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 9 and 11 August 2016 and was unannounced. The inspection team consisted of one inspector.

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 information included in the PIR along with information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met the majority of the people who lived at the service and received feedback from two people who were able to tell us about their experiences. We talked with four visitors.

We spoke with eight staff, which included two registered nurses, care staff, housekeeping staff, the maintenance person, the registered manager. We also spoke with one of the providers. As part of the inspection we sought feedback from health and social care professionals to obtain their views of the service provided to people. We received feedback from two of them.

We looked at the care provided to four people which included looking at their care records and at the care they received at the service. We reviewed medicine records of five people. We looked at four staff records and the provider's training guide. We looked at a range of records related to the running of the service. These included staff rotas, appraisals and quality monitoring audits and information.

Good

Is the service safe?

Our findings

People and their relatives said they felt the home was safe and felt confident they could raise any concerns with the registered manager and nurses. Comments included, "I feel safe now I am here", "Very good here, they are very good" and "Everyone is very well looked after here." A staff member said, "I would be happy for my mother to be cared for here, I would be worried if she was anywhere else. I can't fault the care."

People received their medicines safely and on time. Medicines were stored safely, including those requiring refrigeration. Nurses administered medicines at the home and had received training. Records were kept in relation to medicines received into the home and medicines disposed of, which provided an accurate audit trail. A pharmacist had visited the service in July 2016 and completed a medicines check. They had raised no significant concerns regarding the management of people's medicines at the service.

There was a safe system in place to ensure people had their prescribed creams safely applied. There was a body map clearly highlighting the areas of the body staff needed to apply people's creams. These charts had been signed by the care staff who had administered the creams, and checks were made by senior staff to ensure they had been applied as prescribed.

A homely remedy policy was in place with an up to date agreement signed by the GP, supporting their use for people at the home. The policy set out which additional medicines staff could give people, should they have a need. For example, paracetamol for pain relief and indigestion remedies.

Our observations and discussions with people, relatives and staff showed there were sufficient staff on duty to meet people's needs and keep them safe. Staff worked in an unhurried way and had time to meet people's individual needs. Most people, visitors and staff said they felt there were adequate staff levels to meet their needs promptly. However one person said they had sometimes needed to wait 20 minutes for staff to respond to the call bell. Another visitor said, "When we have rung the bell, they are here almost straight away." Throughout our visit call bells were responded to promptly. The service were scheduled to have a new call bell system installed the week after our visit. This system would allow the call bell response times to be monitored. The registered manager was certain call bells were usually answered promptly. and They said they would monitor call bell response times to check this was the case.

There was always at least one nurse on all shifts. They were supported by four care staff during the morning, three care staff in the afternoon and one care worker at night. They were supported by a maintenance manager, housekeeper, cook and administrator. In addition there was a full time registered manager a deputy manager and senior care worker who had additional supernumerary hours. The registered manager was actively recruiting to fill vacant positions. Staff undertook additional duties and the provider used the services of local care agencies to cover gaps in the rota. The registered manager said they booked agency staff a week in advance to ensure planned gaps were covered. However there had been occasions when agencies had not always been able to provide cover. The registered manager said staff were very good at stepping in to cover short falls.

Staff levels were increased when required to meet people's needs. The registered manager said if they had people with complex needs, who required additional support, staff levels were increased. The registered manager explained they always considered the impact on staff and staffing levels when admitting new people to the service. They gave an example that because they had been supporting some people with complex needs at the end of their lives they had delayed an admission to the home. This was to give staff the opportunity to reflect on recent people's care and to recharge themselves.

There were effective recruitment and selection processes to help ensure staff were safe to work with vulnerable people. Staff had completed application forms and interviews had been undertaken. The registered manager interviewed new staff with the deputy manager or another senior member of staff. Pre-employment checks were done, which included references from previous employers. Any unexplained employment gaps were checked and Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work. One newer member of staff said, "They wouldn't let me start until my DBS came back."

Staff were aware of their responsibilities with regard to protecting people from possible abuse or harm. They had received training about safeguarding people and were able to describe the types of abuse people may be exposed to. Staff were able to explain the reporting process for safeguarding concerns. They were confident action would be taken by the registered manager about any concerns raised. For example one care worker said, "It wouldn't happen here. If it did I would tell (Registered manager) straight away, she wouldn't tolerate it." They also knew they could report concerns to other organisations outside the service if necessary.

People were protected because risks for each person were identified and managed. Care records contained detailed risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments associated with people's nutritional needs, hydration, pressure damage, falls and evacuation needs in the event of a fire. People identified as at an increased risk of skin damage had pressure relieving equipment in place to protect them from developing sores. This included, pressure relieving mattresses on their beds and cushions in their chairs. These were checked daily to ensure they were set at the correct setting to meet the person's needs. Staff were also guided by care plans advising how to reduce the risk of people's skin breaking down. For example, one person's care plan advised staff to wash and apply barrier cream to the person's skin and observe daily.

An individual risk assessment for evacuation of people in the event of a fire at night was in place. This provided information about each person's mobility, visual and communication needs and the support they would require in case of an emergency evacuation of the service. However these were stored in individual people's care files and would not be easily accessible to the emergency service in the event of a fire. We discussed this with the registered manager who said they would set up a file which would be accessible to emergency services.

Accidents and incidents were reported and appropriate action taken. They were reviewed by the registered manager to identify ways to reduce risks as much as possible.

The home had a pleasant homely atmosphere with no unpleasant odours. One relative said, "Never an odour always so fresh." There was a lot of equipment around the home which did look untidy. For example, hoists, wheelchairs and slings. However the equipment was all in regular use for people who required it and was pushed back out of the way to prevent people from tripping over it. Staff had access to appropriate

cleaning materials and to personal protective equipment (PPE) such as gloves and aprons.

Premises and equipment were managed and maintained to keep people safe. There were systems in place to ensure the maintenance person undertook regular checks. These included electrical testing with an annually recalibrated device, effectiveness of window restrictors, hot water temperatures, lift alarm checks and wheelchair checks. Wheelchair checks reviewed the safety of footplates, tyres, brakes and screws. Any found to be unsafe were taken out of use.

The hot water temperature of some tap outlets in sinks were above the Health and Safety Executive's guidelines. The provider had put in place alert signage to make people aware that the water was hot. They had also put up health and safety notice regarding not having thermostatic mixing valves (TMV) in place to regulate the water temperatures. However baths were fitted with TMVs to prevent the water from being above the recommended guidelines. This meant people were not at risk of being scalded during whole-body immersion while having a bath. At the time of our visit, there was nobody at the home who could access the sinks without being supported by a member of staff. We discussed with the registered manager whether new people coming into the service were assessed whether they were at risk if they used sinks without staff support. The registered manager and maintenance person assured us new people were assessed in terms of being at risk of scalding. If there was a risk, any sink they could use would have a TMV fitted to taps to reduce the risk.

External contractors regularly serviced and tested moving and handling equipment, fire equipment and lift maintenance. Staff recorded repairs and faulty equipment. All tasks undertaken by the maintenance person were recorded to ensure there was an audit trail of work carried out. The provider had systems in place to check the water quality at the service annually against the risk of legionella.

A fire service representative had attended the service in November 2015 and had made recommendations regarding some of the intumescent strips (these seals expand in the event of a fire and seal off the gap between the door and the frame). The provider had taken action to remedy these concerns. The maintenance person was a designated fire warden and undertook fire checks and drills in accordance with fire regulations. They updated the fire risk assessment whenever anything changed at the service which was relevant.

Good

Is the service effective?

Our findings

People's needs were consistently met by staff who had the right competencies, knowledge and qualifications. Staff had received appropriate training and had the experience, skills and attitudes to support the complexities of people living at the service.

When staff first came to work at the home, they undertook a period of induction. This included working alongside a designated experienced mentor to get to know people and their care and support needs. The provider used the Care Certificate, which is a nationally recognised Skills for Care training programme for newly recruited staff. Staff said they felt the induction enabled them to perform their role well. One new member of staff said, "I did shadow shifts for the first couple of weeks. We had a discussion and we decided I could go solo. I am able to go to them if I need anything." All new staff receive fire induction training and took part in fire drills and evacuation practices.

Staff had regular opportunities to update their knowledge and skills. Staff had completed the provider's mandatory training which included fire evacuation, infection control, health and safety, manual handling, safeguarding vulnerable adults, equality and diversity and Mental Capacity Act 2005 (MCA). There was further training scheduled for tissue viability, continence and bowel care and nutrition and hydration. Staff were happy with the training they had received. Comments included, "I get a lot from the training" and "The training is wonderful….external and in house training is excellent."

Staff were encouraged to undertake additional qualifications in health and social care and to extend their knowledge further. The provider and registered manager were working with staff deemed as able to undertake an 'Assistant practitioner course' to further extend their role.

The nurses and senior care staff at the service undertook additional training to ensure they had the knowledge and competence to undertake their role. This included verification of death training, catheter care, syringe driver training (a small, portable pump that can be used to give you a continuous dose of painkillers and other medicines through a syringe), venepuncture (taking people's blood) and wound care.

Checks were made by the registered manager to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and registered to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practice within the UK. Nurses are required to undertake a revalidation process to demonstrate their competence. The registered manager had put in place systems to support the nurses at the service to complete the revalidation process.

Staff confirmed they received supervision on a regular basis. They said they found the supervisions really useful and were positive about the support they received. Comments included, "I have the support from the management" and "They told me their impression of how I was progressing and plans for future training. They asked me if I had any problems I wanted to discuss." Observations of staff practice were also undertaken every two months. During these observations, the supervisor checked staff practices in terms of infection prevention and control, health and safety and safe guarding.

People were supported to have regular appointments with their dentist, optician and chiropodist People were also supported to access other health services when necessary. For example, community nurses, speech and language therapist (SALT), and audiology. Health professionals said they had no concerns about the service and had confidence in the staff to make referrals promptly. Comments included, "I go there regularly and referrals are always made in a timely manner and recommendations followed, with staff contacting us if they have any concerns."

An emergency occurred during the inspection visit, which resulted in the person needing to go into hospital. Staff were very responsive to the person's needs. They also consulted with the person's GP and informed their family.

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 be the least restrictive possible.

We checked whether the service was working within the principles of the MCA. We found the home was meeting these requirements. People who lacked mental capacity to make particular decisions were protected. For example where people lacked the mental capacity to make decisions the registered manager and staff followed the principles of the MCA 2005. Records showed that relatives, staff and other health and social care professionals were consulted and involved in best interests decisions made about people. For example, the use of covert medicines.

All staff at the service had undertaken training in MCA 2005 and were able to demonstrate an understanding of the Act. One member of staff said, "We ask four questions to assess whether they have capacity. If they don't meet them then they are deemed as not having capacity and we have to do things in their best interest."

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 procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). The registered manager and staff demonstrated they understood the when to apply for authorisation of DoLS.

The registered manager had made applications to the local authority to deprive 15 people of their liberties and were waiting to be assessed by the DoLS team. The registered manager said they were happy they could contact the local authority DoLS team for guidance when required.

People were supported to have sufficient to eat and drink and maintain a balanced diet. An external company provided meals at the service with a rolling four week menu which took into account people's likes and dislikes. Where people had any swallowing difficulties, they had been seen and assessed by SALT. Where the SALT had assessed a person as requiring a special diet and recommended soft or pureed food, these meals were provided by the external provider in the required consistencies for people who. Staff were aware of the importance of people's position when eating and of the need to give the person plenty of time to swallow between mouthfuls of food. People were happy about the food and said they were offered a choice if they did not want what was on the menu. Comments included, "Food is alright but could be improved. I am fussy, I know what I like. I do get a choice" and "The food here it is very good."

Staff gathered information about people's dietary requirements likes and dislikes when they first arrived at

the home. This information was available in the kitchen for the catering team to inform them about people's requirements. Staff were also guided by a list of people's preferred of cold drinks for their jugs in their rooms. People at risk had their weight monitored regularly and further action was taken in response to weight loss and appropriate referrals made.

Good

Is the service caring?

Our findings

Staff were kind, friendly and caring towards people. People were seen positively interacting with staff, chatting, laughing and joking. People and visitors said they felt the care at Linksway was very high. People's and relatives comments included, "All the staff are very nice. I give them as good as they give me"; "I think it is lovely. The size of the rooms are excellent. The staff give very good care, they do their job well. I am made to feel very welcome. I can go and have a cup of tea. If I get upset they talk to me. They all do a good job", "Like family to me, I know them all so well…I could not ask for anything more of them, kindness itself. As a family we count our blessings that (relative) came here" and "They are always bringing him things. The girls here are generally very helpful, caring and cheerful. His care here is good; he is kept clean and kept comfortable."

Staff were considerate and caring in their manner with people and knew people's needs well. When someone was brought into the lounge staff were very attentive and spoke and reassured the person throughout being transferred into a chair using a hoist. They then ensured the person was comfortable and had all they needed, which included a blanket over their legs. One staff member said, "The staff are extremely professional. The majority of them are very personally involved it's not just a job."

Staff treated people with dignity and respect when helping them with daily living tasks. Staff said they maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering, covered people and gained consent before providing care. One person said, "They pull the curtains across if doing anything personal." One staff member said, "When assisting someone to use the toilet, we take them back to their rooms, make sure the door is closed and curtains shut. Everyone knocks on the door before they come in." Another said, "we cover their bottom half with a towel or blanket." Always make sure they are covered and dignified." There were designated dignity champions at the service. The registered manager explained how one was a strong advocate for people in the home. A meeting had been held with the dignity champions to discuss how to move forward as a member of staff had left.

The provider's 'residents charter stated, 'To be encouraged to maintain independence, choosing whenever possible their own level of freedom, habits and lifestyle. To be encouraged and assisted in maintaining a high quality of life with respect for the resident's individuality.' We saw that staff involved people in their care and supported them to make daily choices. For example, people chose where they spent their day and the clothes they wore. Staff said they knew people's preferred routines such as who liked to get up early, who enjoyed a chat and who required reassurance and emotional support. In people's care plans staff were reminded to seek implied consent from people before carrying out tasks. People and their families had also been involved in completing a 'personal choices sheet'. These asked about people's preference of gender of carer, if they required a protective apron while eating, time they would like to get up and foods they particularly liked. Formal consent was also obtained regarding having their photographs taken.

People's relatives and friends were able to visit without being unnecessarily restricted. People and a relative said they were made to feel welcome when they visited the home. One visitor said, "I am always asked if I would like a drink. I can't fault the staff here." A relative had sent a thank you card saying, "like to

compliment the staff for the very warm welcome our friends receive when they come to Linksway. Having to ring the front door bell to come in never seems to pose a problem. A friendly greeting is always given. Our friends have been brought up in the lift with assistance… They are always offered a cup of tea or coffee and generally made to feel welcome."

The atmosphere at the home was calm and welcoming with people living there appearing 'at home'. The staff were aware that it was people's home and did not rush around carrying out tasks. There were comfortable communal areas for people to use as they pleased. However due to people's physical health needs and choices only four people used these areas during our visit. People's rooms were personalised with their personal possessions, photographs and furniture.

The provider offered palliative and end of life care. There were six people requiring this support at the time of our visit. The staff discussed people's end of life wishes with people and an end of life care plan was put into place. This ensured people's individual wishes would be carried out by the staff. The registered manager said they were so proud of how good the pain management was at the service. She said "it is anticipated and action taken quickly."

People, when required, had access to support from appropriate health professionals including the hospice team. A member of the hospice team was positive about the quality of care given to people they had supported at the service to receive end of life care. Their comments included, "Responsive to people's needs and the staff follow my advice appropriately and are very happy to work with me as a specialist. I feel the service is well led and consider that people under their care receive the appropriate end of life care."

A relative of person who had passed away at the home had written a thank you card. They wrote, 'Thanks to all of your staff for the care and attention they have given (person) over the years…making the final stages of her life so comfortable…very impressed by your expertise and concern.'

Arrangements had been put into place for a relative who had been a regular visitor to the home to visit a person who had now passed away. They did small administration tasks at the home every other week which assisted the staff and helped the relative to keep in contact. The registered manager was also providing pastoral support to two other relatives who had lost someone at the service.

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs, preferences and diversity. Care plans gave information about people's health and social care needs and showed that staff had involved other health and social care professionals when necessary.

The provider recorded in their provider information return, 'Pre-assessment prior to admission to include resident, relative's hospital staff or current carers. Families are requested to provide social care information prior to admission. Person centred care plans which are reviewed regularly with residents and relatives. Allocated named nurse and key workers to facilitate consistent coordinated care that is responsive to the residents needs and acknowledgement of the residents mood, wishes and choices and all documented accordingly.' Records we looked at confirmed this was happening. One relative said, "When we came here we met with (registered manager) and went through everything. I am informed about everything. They call the doctor regularly. I am quite confident and trust them implicitly in (relatives) care."

The information gathered at the pre-admission assessment was used to generate care plans. These were used to guide staff to know how to provide the care people required when they moved into the home. This ensured people's care plans were reflective of their health care needs and how they would like to receive their care, treatment and support. The care plans covered people's personal care and hygiene needs, mobility, continence, communication, tissue viability and religious spiritual needs. For example, one person's communication care plan identified the person was unable to verbally express their needs due to advanced dementia. The care plan guided staff to watch the person's face for indications. For example, if the person was grinding their teeth they might be agitated, or singing could be a sign of being upset. People also had a daily oral care plan. Where people had their own teeth staff were guided to assist the person with brushing their teeth twice a day. If they had a dry mouth staff should offer frequent fluids.

People's care folder included personal information and identified the relevant people involved in their care, such as their GP, optician and chiropodist. There were also bedroom care folders. These contained the care plans, the person's family tree with details about people's interests, family and friends and education and employment likes and dislikes. This meant that when staff were assisting people they knew their choices, likes and dislikes and provided appropriate care and support. The staff were required to record all interactions with people and the support they gave in these folders. The care files were presented in an orderly and easy to follow format. One relative said, "They do the paperwork when delivering care straight away."

Relevant assessments were completed and up to date, from initial planning through to on-going reviews of care. Each month the designated staff member would review people's care needs. They would involve people and their relatives according to their individual wishes.

Staff said they found the care plans helpful and were able to refer to them at times when they identified changes in a person's physical or mental health.

The registered manager recognised the risk to people of social isolation and that activities formed an important part of people's lives. They were in the process of recruiting a new 'support officer' to oversee activities provision at the home. A notice in the staff room explained to staff that the support officers' primary function would be to support people in a more focused person- centred way. One relative said, "The staff are always friendly. There always used to be a lot of activities but due to the residents' needs it is not possible anymore." Another said, "We can bring pets in here. The care staff here work hard and have to put up with a lot. It is difficult work." The majority of people at the home were being nursed in their rooms because of their physical health needs. Care plans had been put into place to prevent isolation and promoting personal choice for a person who, for health reasons, needed to stay in bed. Staff were spending time with people on a one to one basis when possible. Entries of activities undertaken in people's records included, nails cut and varnished and a newsletter being read. There were bird feeders all around the home with some on poles outside people's rooms so they could enjoy watching the birds feeding. The monthly newsletter made people aware of the external activities available at the home and changes being made. Each person was given a copy and we saw they were on display on people's notice boards in their rooms. The registered manager said families could also have a copy if they request one.

The provider had a complaints procedure which made people aware of how they could make a complaint. This was displayed in the main entrance and in booklets in people's rooms which also contained the names of the home's dignity and diversity champions. The complaint procedure identified outside agencies people could contact if their complaint was not resolved to their satisfaction. This included, the local government ombudsman.

People and relatives said they would feel happy to raise a concern and knew how to. Comments included, "I could go to any of them, they would all sort it out, they are brilliant here."

There had been no formal complaints received at the service in the last year. Where the registered manager had been made aware of grumbles they had taken them seriously and had taken action to ensure people were happy and satisfied with the outcome.

Good

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with the CQC. People and relatives were positive about the registered manager. They said she was approachable and always available if they wanted to talk with her. Comments included, "Is an amazing lady, I can talk to her about anything" and "is amazing, so caring and lovely, nothing is too much trouble."

Staff were also complimentary about the support they received from the registered manager. Comments included, "Very professional, very involved with the wellbeing of staff and residents, very easy to get on with" and "I can go to her anytime."

One of the provider's visited the service most weeks and stayed for a couple of days. They had discussions with the registered manager, staff, people and visitors during these visits. The registered manger spoke with the provider's most days and sent them weekly reports. This included information about, occupancy levels, staff supervisions undertaken, staff absences planned and unplanned.

The registered manager was supported by a deputy manager and nurses who undertook the day to day running of the service. The registered manager undertook one or two nursing duties a week when required for example, during the holiday period. Everyone had a clear understanding of their responsibilities and referred people appropriately to outside healthcare professionals when required. The staff knew each person's needs and were knowledgeable about their families and health professionals involved in their care. Senior staff promoted a positive culture by supporting staff. This included recognising staff abilities, supporting them to develop their skills. Senior staff also challenged poor practice if they identified it.

Staff said they felt well supported by the registered manager, nurses and senior care workers, they said issues were dealt with quickly and appropriately. One new care worker commented, "The morale here is good, everyone is very mature and supported well. There is a counselling process if staff require it. It is fortunate staff here have been here for years. I have been very impressed with how professional they are." Another said, "Really enjoy working here…getting on with the staff. I enjoy looking after the residents. I feel supported."

There were accident and incident reporting systems in place at the service. The registered manager monitored and acted appropriately regarding untoward incidents. They checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns they took action to find ways so further incidents could be avoided. They also completed an annual audit of accidents and incidents at the service. This enabled them to be able to analyse trends to establish whether there were any patterns. Where a pattern was identified, actions were put in place to reduce the risk of recurrence.

The registered manager had a range of quality monitoring systems, including audits which were used to continually review and improve the service. They had taken appropriate action for issues identified in the audits. There were regular audits of medicines, care records and health and safety, which included infection

control. For example as part of the monthly infection control audit, checks were made regarding the cleanliness of mattresses, bed rail bumpers, beds cleanliness and staff handwashing. A monthly environmental audit was completed by the provider accompanied by the maintenance person. They looked at outbuildings, bins, lights, internal and external doors, sluices, toilets, laundry, kitchen, grounds and garden. The outcome of these checks were recorded as well as actions undertaken since the last environmental audit. For example, carpets shampooed and bulbs replaced. An external annual Insurance report was also completed and anything highlighted in that report was actioned promptly.

To ensure people received good end of life care, the registered manager had completed a palliative care audit in July 2016. This was to assess the support people required as well as the impact on the person, their relatives and staff. The audit considered what the service did to ensure people were comfortable and whether anything could have been done better.

The providers kept up to date with the most recent guidance and shared their findings with the staff. For example, in April 2016 they read guidance regarding people's hydration needs. This was brought to the attention of the registered manager and staff. This had resulted in discussions about having a hydration champion and looking at training in how to identify signs of dehydration.

People and staff were actively involved in developing the service. It was not always possible to hold a 'residents meeting' because of the complexities of people's needs. The registered manager explained that individual meetings were held where relatives and friends, where appropriate, were invited to come. At these meetings they discussed people's care needs and any concerns or suggestions they might have. Staff said some people had monthly meetings, others chose every couple of months where some chose not to have a meeting.

The provider conducted an annual survey of people, relatives, staff and health and social care professionals in the months of October and November. The responses from the last survey had been very positive. People and staff had been advised of the responses and any changes which had been made as an outcome. For example, staff had commented that communication at the home could improve. The registered manager was looking at ways to improve the communication. The registered manager also undertook small surveys where people were asked one question about the service. Examples of these included, who they would go to if they had a concern; did they get to go to bed and get up as they chose.

Whole staff meetings were held a couple of times a year. The registered manager said that the frequency varied depending on what needed to be discussed. For example, if while undertaking staff supervisions there was a trend which needed addressing. The registered manager also met with the nurses and housekeeping staff regularly to discuss issues specific to these roles. Records of these meetings showed staff were able to express their views, ideas and concerns. Between each shift there was a handover to give staff key information about each person's care and any issues brought forward.

In March 2016 the service was inspected by an environmental health officer to assess food hygiene and safety. The service scored the highest rating of five, which confirmed good standards and record keeping in relation to food hygiene had been maintained.

Records were stored in the staff office which was at the back of the service and was unable to be locked. The registered manager assured us that people's care records were secure in a locked cupboard and would not be accessible to visitors.

The registered manager was meeting their legal obligations such as submitting statutory notifications when

certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested.