Methodist Homes

Abbey Park

Inspection report

Humber Road
Coventry
CV3 4 FE
Tel: 02476 506045
Website: www.mha.org.uk/ch34.aspx

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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

Overall summary

This inspection took place on 10 June and was unannounced.

Abbey Park is a nursing home that provides care for up to 84 people who require specialist nursing, palliative, rehabilitation and dementia care. The care is provided in separate units over two floors. On the day of our inspection there were 58 people living in the home. We were told about planned changes to reduce the range of care the home would be providing. This included the withdrawal of the palliative care service.

At our last inspection on 22 July 2014 we found the provider had not ensured there was an effective system to manage people's medicines to protect people from the risks associated with medicine management. The provider had also not ensured records were clear and detailed to protect people from the risks of unsafe or inappropriate care.

The provider sent us an action plan outlining how they would make improvements to medicine management and records. During this inspection, we found the necessary improvements had been made. The one

Summary of findings

exception was that a medicine that presented particular risks had not been stored securely and the registered manager took action on the day of our visit to address this.

A registered manager was in post. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had a good understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) so that people who lacked capacity to make decisions could be appropriately supported. Staff were clear about their responsibilities in relation to the MCA and the need to gain people's consent before delivering care.

People felt safe and at ease to raise any concerns with staff if they needed to. They told us most of the time there was sufficient numbers of staff to keep them safe. Staff had completed essential training to meet people's needs, this included training in safeguarding people so they knew how to recognise abuse and take the necessary actions to protect people.

People told us the staff were caring and treated them well. Staff knew about people's needs and told us people's wishes and preferences were clearly documented in care files so that staff knew about them. Most people spoke positively about the social activities and entertainment provided and we found people were supported to follow their interests and take part in these.

People were provided with choices of nutritious food that met their dietary needs. People were mostly positive in their comments about the food provided and told us there were alternative choices offered if they did not like what was on the menu. There were regular choices of drinks available during the day, and where necessary, people were supported to eat their meals.

There was clear leadership within the home. On each unit there was a care manager or nurse who oversaw the organisation of each unit and care staff reported to them. The registered manager and deputy manager carried out a range of quality checks which were reported to the provider as part of a system to assess and monitor the quality of care and services provided. This meant the provider played an active role in quality assurance and ensured the service continuously improved.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were sufficient numbers of staff to support people's needs and manage their care. Potential risks to people's health were assessed and appropriately managed to keep people safe. New staff were subject to recruitment checks to make they were safe to work with people in the home.

People received their medicines as prescribed and records were clear to demonstrate this. A potential risk relating to the storage of one medicine was addressed on the day of our visit.

Good

Is the service effective?
The service was effective.

Staff had access to on-going training to ensure they had the skills and knowledge required to meet people's needs.

People were provided with a choice of drinks and meals that met their dietary needs and support was provided to people who needed help to eat. Health professionals were involved in people's care where needed.

Good

Is the service caring?
The service was caring.

Staff supported people in a caring and kind manner. However, sometimes staff missed opportunities to engage with people, in particular with those people with a diagnosis of dementia.

Staff were knowledgeable of the people they cared for and recognised the importance of maintaining their privacy and dignity.

Good

Is the service responsive?
The service was responsive.

People were involved in planning their care and spoke positively about the social activities and entertainment provided. We found people were supported to follow their interests and take part in these.

There was a process for people to report any complaints and these were acted upon in a timely manner although responses were not always formalised in writing. Learning was taken from complaints and was communicated to staff individually to help prevent them from happening again.

Good

Is the service well-led?
The service was well led.

Quality checks were carried out to drive improvement within the home. The provider had taken action to address areas for improvement we identified at the last inspection.

Staff spoke positively about the service and felt they were given opportunities to suggest ideas for improving the quality of care and services provided.

Good

Abbey Park

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 10 June 2015 and was unannounced. The inspection visit was carried out by three inspectors, a pharmacist, an expert by experience and a nurse specialist advisor. An expert-by-experience is a person who has experience of using or caring for someone who uses this type of care service. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in providing nursing care.

As part of the inspection, we reviewed the information we held about the service. We looked at information received from agencies involved in people's care and spoke with the local authority. They told us the service had improved since our last inspection. We analysed information on statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection of the home.

We spoke with 12 people who used the service, 15 relatives and friends plus four visiting health professionals. We also spoke with the registered manager, deputy manager, service manager, deputy service manager, music therapist, activity co-ordinator, chaplain, activity facilitator, administrator, the care manager of Stoneleigh, five nurses, five care staff, a moving and handling co-ordinator, the chef and their assistant.

We spent time observing how staff interacted with people across the five units in the home. In some cases we also used the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experience of people who were not able to talk with us. The five units we observed were: Arden and Avon (both elderly frail nursing with some people with dementia), Whitefriars palliative care unit, Greyfriars unit for people with dementia and Stoneleigh unit which provided some short term care as well as palliative care. We checked medicine management for 13 people across three units (Whitefriars, Greyfriars and Arden). We looked at 11 care plan files and observed people in lounge, dining and bedroom areas to see how they were cared for.

We also looked at complaint records, thank you cards, quality monitoring audits, training records, an external fire risk assessment, quality satisfaction questionnaires, accident and incident records, safeguarding records, staff meetings, relative meetings and building security and safety checks.

Good

Is the service safe?

Our findings

At our last inspection on 22 July 2014 we found the provider had not ensured there was an effective system to manage people's medicines to protect people from the risks associated with medicine management. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan outlining how they would make improvements. During this inspection we found the necessary improvements had been made.

We looked at how medicines were managed for 13 people over three units. We found people received their medicines as prescribed. Appropriate arrangements were in place to store medicine safely and manage the risks associated with the unsafe use and management of medicines. The only exception to this was the storage of medicine given via a syringe driver. A syringe driver is a small portable pump that can be used to give a continuous dose of pain relief and other medicine through a syringe. The syringe should be kept in a locked box to prevent the risk of it being tampered with and impacting on a person's health. We found a locked box was not being used for one person who was receiving their medicine through a syringe driver which placed them at risk. The registered manager took action on the day of our visit to make sure a locked box was fitted.

Medicine administration records (MARs) were completed to show if people had been given their prescribed medicines. Suitable arrangements for accurate medicine stock checks meant it was possible to check the balance of all medicines to ensure they had been given as prescribed. Arrangements were also in place to ensure that hand written MAR charts were accurate. We saw records documented when people had been given their medicines or a record was made to explain why it had not been given. We found people's medicines were available to treat their diagnosed health conditions and people told us their medicines were given by the nurse at the times they expected to receive them.

Regular medicine checks were undertaken. We were shown copies of the medicine checks which showed that any issues of concern were dealt with by the nursing staff team or management. In particular, improvements had been made to ensure medicines prescribed for pain relief on a specific day in the week were available and given on the correct day. We acknowledged these improvements which helped to ensure people were safe from harm. People felt their pain was being managed well and one person told us, "I can ring and ask for additional pain relief."

There was an open culture of reporting medicine problems and shared learning between nursing staff. Medicine errors were dealt with immediately in order to learn and prevent the error happening again.

At our last inspection on 22 July 2014 we found the provider had not ensured people were protected from the risks of unsafe or inappropriate care because records were not always sufficiently clear or detailed. This was a breach of Regulation 20 (1) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan outlining how they would make improvements. During this inspection we found the necessary improvements had been made.

Care records were sufficiently detailed to show how people's care was being managed and we saw staff followed instructions in care plans to meet people's needs. Risks associated with people's care were identified and reported to the management team to enable these to be monitored. Clinical risk assessments had been completed where there were specific risks around people's health such as refusing medication, losing weight or skin damage. Risk assessments were reviewed on a monthly basis to identify any changes to risk and to show how these risks should be managed to meet people's needs. For example, a management plan for one person at risk of skin damage read, "Check on every intervention, report concerns to nurse. Encourage to change position regularly. Well balanced diet and regular fluids. Foam mattress. Apply Cavilon as prescribed."

Some people required specialist equipment to manage the risks associated with their care. For example, one person's care plan said they had to wear a palm protector. There were good photographic instructions informing staff how this was to be put on. We saw the person was wearing it when they were sitting in the lounge. There was equipment to enable people to be moved around the home safely. This included mechanical hoists and wheelchairs. Nursing equipment to manage risks associated with people's needs such as suction machines and specialist mattresses were available and staff knew how to use them to keep people

Good

Is the service safe?

safe. Care staff told us if they were unsure how to use a new piece of equipment they would ask for specific training. They stated that they knew any such request would be approved immediately.

We found people's health and any risks identified during the day or night were discussed during a period of handover at the start of each shift. This enabled both care staff and nursing staff to be kept updated on people's needs and any concerns that may need monitoring.

All the people we spoke with told us they felt safe. People told us, "I feel very safe, when I press my call button they come quickly." "Yes I feel pretty safe, they are a lot of lovely girls here." "I have to make sure I have oxygen and when I get breathless they come straight away that makes me feel safe." Relatives we spoke with felt their family members were safe in the home. One commented, "I come at different times and find the staff are really good."

Staff told us they had completed training in safeguarding people from abuse. They understood their responsibilities for keeping people safe and knew about the different types of abuse. They said they would report any concerns to their manager. Staff told us, "I would not hesitate to challenge any member of staff who I felt was not caring for a patient in an appropriate manner." "There would be a serious investigation. I would take them (staff) off the floor and inform the manager." Staff told us they felt any concerns they reported would be listened to and acted upon by the registered manager. Staff told us there was a whistleblowing procedure in the office if they felt they needed to use it. One person's care plan identified an incident when there had been an altercation with another person which had resulted in a slight injury. This had been appropriately reported to us and to the local authority safeguarding team so that it could be appropriately investigated.

Whilst walking around, we noted that, overall the units were clean and well maintained. However, there were some unpleasant odours noted in specific areas of the home for some parts of the day. A relative told us, "[Person's] room is clean. Sometimes you do pick up smells, more in the evening, but we are happy with the care she is getting here and the environment." This information was passed to the registered manager so she could investigate the cause of these odours. We saw records which confirmed regular maintenance checks of the building were carried out to ensure the environment was safe for people. There were also regular service checks on equipment in use within the home to ensure it was safe to use.

Corridors were clear allowing those with reduced mobility to move around safely. However, we noted two people who we were told could use a call bell, did not have it to hand when they were in their room. This would have made it difficult for them to alert staff if they needed them and this information was therefore passed to the registered manager. We also found a door directly from the car park into the home was left open and was not in an area observed by staff. This meant there was a risk people could enter the home without being checked. These concerns were reported to the registered manager so she could take any appropriate actions.

Staff were clear on the procedure to follow in the event of a fire or emergency. They were able to describe the evacuation process and were aware of how to support people with different care needs. People had personal evacuation plans so it was clear how they would need to be supported in the event of an emergency.

Accidents and incidents were recorded including information about the action taken to address people's injuries. The registered manager analysed these to identify any trends such as times, location and repeated falls. This was so she could take action to minimise the risk of these happening again and to ensure lessons were learned.

People told us they felt there were enough staff to meet their needs. People told us, "Yes on the whole there is enough staff. At the moment they are short staffed with holidays but it's usually ok." A visitor told us, "I think they could do with more staff. Sometimes staff seem to be a little thin on the ground but I have always found somebody. The majority of the time it is fine." Another visitor told us "Mum hasn't wanted for anything."

We observed there were sufficient staff available to support people. Call bells were answered promptly and those people cared for in bed were visited frequently by staff. All the staff we spoke with told us most of the time there were enough staff to meet people's needs safely. They told us, "We don't have any staff problems, we are quite full." "Staffing levels are alright. If we are short we get people in immediately." "We would all like more staff but we are doing alright."

Good

Is the service safe?

We spoke with staff about how they were recruited to the home. Staff told us they had to wait for police and reference checks to be completed before they were able to start work. The registered manager confirmed that new staff members were not able to work at the home until all their recruitment checks had been completed. This included a Disclosure and Barring Service (DBS) check to make sure they did not have any criminal convictions that would prevent them from working with people who lived at the home.

Good

Is the service effective?

Our findings

People and visitors across all units felt staff had the knowledge and skills to support people safely. People told us, "I do think the staff know what they are doing." "Yes, by and large they have the skills to do the job, I am comfortable with them." Relatives told us, "You feel nobody can look after them like you but this is second to that." "I think so (staff have the necessary skills), if they are not sure about anything they will always go and find somebody who can answer." "I think they do and as they have got to know her better it is much more tailored to her."

Relative feedback cards we saw on the palliative care unit were very positive about the care provided. One stated, "You have the greatest degree of compassion and understanding, and the highest professional standards."

Staff completed essential training on a regular basis to support them in their roles and the registered manager checked staff completed their training when required. Staff told us their induction training was thorough and they could not work unsupervised until they had completed all their training. One staff member told us, "It was one month. I was shadowing (working alongside other experienced staff) for three weeks and had one week of training." Staff were complimentary of the training they received. They told us, "We have good training. I had challenging behaviour training eight weeks ago. I am due palliative training." "Very good. We have people from outside come in (to provide the training)." Nurses told us their training was available in the form of study days and they were encouraged to complete reflective diaries (this is where they look at how they managed something and if there was anything they could have improved upon). A visiting health care professional told us they thought the level of care at Abbey Park was "very good" and when asked if staff had the appropriate skills said, "If they haven't they know where to source another member of staff who has."

The registered manager told us they did not accept people into the home until they knew the staff were suitably trained to meet their needs. A nurse confirmed this and explained the process staff had undertaken to ensure they were fully aware and knowledgeable of one person's complex nursing needs. Training had been provided by the local hospital prior to the person's admission to the home so staff could meet the person's need safely. The contact names of staff in the hospital were also clearly displayed in the person's notes should any issue of concern arise. Nurses told us about a regular meeting that took place with the palliative care medical consultant and the community Macmillan nurses. This enabled them to share information about people's on-going care to ensure this remained of a high standard and was effective.

Staff had regular supervision and an annual appraisal where they discussed their roles, any concerns, and their on-going training and development needs. The registered manager told us she regularly observed staff working to identify if they were putting into practice the provider's policies and procedures. Where she identified a training need, additional periods of supervision were arranged with the staff concerned to remind them what was required. Staff confirmed that supervisions happened more often if there were any problems about the way they worked or if they had concerns themselves. Staff told us, "We have supervision with our line manager every three months, unless you have any concerns, and then it would be earlier than three months." "It's useful, we look at how things can be improved, what has gone well." Care staff told us that they felt "well supported" in their roles by senior nurses and the management team.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

The MCA ensures the rights of people who lack mental capacity are protected when making particular decisions. DoLS referrals are made when decisions about depriving people of their liberty are required, to make sure people get the care and treatment they need in the least restrictive way. Where people lacked capacity to make certain decisions, capacity assessments had been completed so that staff would know to support these people in decision making.

People told us their consent was sought before staff delivered care and we saw this happened. One person told us, "Staff don't just commence with my personal care, even if they are a little late they enquire with me if it's still alright."

Staff demonstrated a good understanding of the issues around mental capacity and the importance of giving people time and information so where possible they could make their own decisions. Comments from staff included:

Good

Is the service effective?

"You have some who have capacity and you have some who don't have capacity. You know your residents, whether they are capable or not, but it's in their care plans. You shouldn't assume someone hasn't got capacity because they are here." "Some people do have capacity. We talk to them and explain everything before we do anything for them. They are able to express their needs. It is a very hard thing to say someone doesn't have capacity so there is always more than one meeting before we do that." One person who was at risk of developing sore areas on their skin had refused to have a higher protective mattress to reduce this from happening. The manager told us this had been discussed with the person who had been informed of all of the risks but this was their choice and staff had respected the person's decision.

The manager had made DoLS referrals where people lacked capacity to make certain decisions. Referrals contained information that demonstrated the registered manager's knowledge and understanding of the required processes in relation to the MCA and DoLS.

People were mostly positive in their comments about the food provided and told us there were alternative choices offered if they did not like what was on the menu. Relatives were also positive in their comments about the food served in the home. They told us, "Lovely some Sundays I have my dinner here. It is proper cooked food." Another said their relative could be fussy and commented, "I think they do go out of their way to help her." Each of the units had kitchenettes where staff could prepare drinks for people on request. We saw when people requested drinks these were provided. At lunchtime we observed the mealtime experience on four of the units. Staff served the food from a hot trolley on each unit. Meals looked nutritious and were well presented. Most people were able to eat independently. Those people who needed support were assisted by staff who sat beside them. On the dementia unit staff asked people if they wanted orange or blackcurrant drinks but the jugs were coloured so people could not see what was in them to help them make a choice. A staff member realised it was a problem and poured out a glass of each drink so people understood what options they were being given. Water was not given as an option. We were told about one person who required a vegetarian diet for cultural reasons and we saw they were given a vegetarian choice.

Care files showed that people's weight was regularly monitored to make sure they were eating sufficient to maintain their health. Records confirmed when there were concerns about people's nutrition, they were referred to health professionals for advice and support. Care plan records showed that a person who had developed a pressure ulcer had been regularly monitored and when there had been concerns about these, contact had been made with the person's GP. There had been regular contact with a specialist 'tissue viability nurse' for advice on dressings and management of the ulcers. Photographs confirmed the nursing interventions were supporting the healing of the wound.

People told us they were able to access health professionals when needed. People told us, "Yes I see the people I need. I've just had the chiropodist and the doctor comes regularly." "I have arranged the dentist myself as I am able, yes staff would arrange it." A relative told us, "When [person] wasn't eating properly they got the dietician out." Staff said they referred people to specialist external healthcare professionals when a need arose. One staff member told us, "We refer them to the specialist they need. We have a nurse practitioner who comes every day but Thursday and the weekend. The GP comes twice a week."

Two visiting healthcare professionals told us staff followed their advice and staff contacted them if they needed to discuss any concerns or problems. One health professional told us they had no concerns about the on-going support for the person they visited. They felt the staff were "proactive" in contacting the community service if they had any concerns about the person in between their visits.

Good

Is the service caring?

Our findings

People told us the staff were caring and treated them well. They told us, "The staff are so caring, they hate to see me in pain and when they turn me they are so gentle, they really feel for me." "Staff treat me really well."

Visitors also felt the staff were caring towards their relatives. They told us, "I think they are caring. The ones I see and my wife see, we have never had an issue with staff." "[Person] does get agitated but the staff are very good with her." "I find them very caring."

We received positive comments about the palliative care unit and were told about how the unit provided on-going support to relatives. There was a 'wives club' that had been set up to provide on-going support to relatives of people being cared for on the palliative care unit as well as relatives of people who had passed away. There had been attempts to also support husbands/partners but there had been no take up of the offers made. Comments about the care included, "The palliative care unit was a little haven to me and my mum." "You have the greatest degree of compassion and understanding, and the highest professional standards." "Compassion, gentleness, dignity and sensitivity were so much in evidence."

We asked staff what they thought made them caring. One staff member told us, "It is knowing your job, talking to your residents, knowing each individual. They are here but they have individual needs. It is about doing the best you can for that individual." Another stated, "This is a dementia unit but everyone is so relaxed because they know people. That's what makes it great, the people." We observed staff engaged with people who had communication difficulties because they had built a rapport with them and were caring in their approach. This showed people were not excluded and staff had taken the time to understand their needs despite their communication difficulties. For example, one person had lost their ability to communicate well in English which was their second language. We observed a member of staff took the time to speak with this person in their first language which reassured them. The person's relative told us, "It is good. [Person] doesn't speak much English so there is a language barrier. There are nurses and care staff here who do speak their language so it isn't a barrier we haven't been unable to overcome."

We asked staff how they supported people to make choices if they had limited communication or found it hard to concentrate. One staff member told us, "We have to find a common ground with them. You have to find something they really enjoy, they will share with you and they will share other things as well."

During the day we saw people on one of the dementia units becoming anxious and distressed. Staff took time to reassure and talk with them. Staff also provided physical reassurance such as holding a person's hand or rubbing their back which had a calming effect.

Staff knew about people's past histories so they could hold meaningful conversations with them, but sometimes missed opportunities to engage with and provide stimulation to people. For example, there was very little interaction with people when providing them with their lunches or when supporting them to eat. On one of the dementia units staff put the meals down without any conversation about what was on the plate. When we asked one relative how they would improve the service they replied, "I think it would be more staff talking with the residents, sitting with them and having a conversation. It is nice to see people being spoken to. I think I would like to see more interaction." This information was fed back to the manager so that she could address this issue.

Staff we spoke with were knowledgeable about the needs of the people they were caring for and knew about their preferences and how they wished their care to be delivered. They told us about one person who could become extremely anxious when receiving personal care and commented, "You have to know the routine for him. It is quite different to any other resident basically." There was a detailed care plan in place so staff knew how to reduce and manage the person's anxiety. This included instructions to remain calm if the person became agitated.

People were able to make decisions about their care such as where they sat, what they ate, what clothes they wore and what activities they attended. We observed staff offering people who had high care needs a choice in the time they would receive their personal care according to their comfort levels at the time. Visitors felt involved in decisions relating to people's care. Visitors of one person told us they had been told about their relative's deteriorating condition and had been given the opportunity to talk to the person's GP. They were able to discuss the person's treatment and the changes that were

Good

Is the service caring?

taking place. They had no concerns over the care and said, "Everything that could be done is being done." Another relative told us, "I think the staff are lovely. I have a lot of time for [staff member]. He has a world of patience. He is lovely. He really keeps me up to date.

We asked people if they felt their privacy and dignity was respected. People told us, "Well they are pretty good, staff treat me kindly with dignity and respect when I have shouted at them." "Definitely respectful, no 'if's' about that!" Visitors also felt their relatives were treated with respect and their privacy and dignity was maintained. They told us, "Definitely. My oldest daughter said at least we can sleep at night because they treat him with dignity and love." "Some mornings when I come in I will give [person] a shave and then the girls will say 'you go and have a cup of tea and we will do the rest'."

Staff knew about the importance of maintaining people's privacy and dignity. They told us, "It is covering them up when you wash them. Giving them choices. With some it is difficult but if you put different choices in front of them, they will point."

Good

Is the service responsive?

Our findings

We asked people and their relatives if they were involved in planning their care. One person told us, "Indirectly yes, my daughter directs them. My daughter gets involved, I prefer her to look at the care plans for me." "Occasionally they have done."

Staff told us a comprehensive assessment of people's needs was undertaken with people at the time of their admission to the home. They also told us people's wishes and preferences were clearly documented so that staff knew about them. We were able to confirm this when we looked at care plans. These reflected how people liked to receive their care. Where people had short term health problems, care plans had been developed for staff to follow to make sure these needs were met. Staff told us that relatives were encouraged to sit in at review meetings and take an active part in the care planning processes. Care plans showed that people's needs had been reviewed on a regular basis to identify any changes in support and to ensure this was provided as necessary.

Care plans contained information about people's spiritual well-being as well as their mental health and physical needs to make sure they received care centred on all of their needs. One care plan read, "Staff to spend time sitting and talking to [person] about his life, family and contemporary events. Sit and watch TV with him, maybe related to engineering, bowling, snooker ….. Encourage to go on day trips." Their relative confirmed these were the person's interests. There was information about how staff should respond to people's mental health needs. For example, one person's care plan stated staff should ensure soothing music or the television was on but not conflict programmes as they would upset them. We saw staff ensured the television was on an appropriate channel for the person.

We saw staff were responsive to people's needs. When one person became anxious, staff took the time to find out why so they could address their needs. This included asking if they were in pain. When we spoke with one person they told us there was a fault with their electrical bed and they had told the nurse that morning. We saw a member of the maintenance team arrive and resolve the problem so that the person could adopt a more comfortable position. The person commented, "They are really good, they sort things out quickly." The registered manager told us about one person who had requested soya milk and arrangements had been made for the cook to prepare milk based foods such as custard separately for this person. We asked a relative if staff actioned their requests and they responded, "Yes, the other week was [person's] birthday. I brought him new clothes and I asked if he could be dressed in them in the morning and he was."

Most people spoke positively about the social activities and entertainment provided and felt supported to follow their interests and take part in these. People told us, "There are things to do, a few weeks ago we went out for the day." "I join in (activities), if you want to join you can." One person told us they did not feel their interest in sport and DIY were supported but stated, "I have joined in three activities, a singer, a sing-along and a 'men's' group." There was an activity co-ordinator, chaplain and activity facilitator who told us they worked together to engage people in activities they wanted to be involved in. We saw photographs of people smiling when attending outings, shopping trips and parties showing they enjoyed them. We were told people who were unable to attend social activities due to their ill health, including people cared for in bed, were supported on a one to one basis. This support was provided by the 'social care facilitator' who told us they had been employed specifically to carry out this role.

The music therapist told us how they supported people who were living with dementia by using music therapy. They told us this reduced the symptoms associated with dementia and improved people's quality of life. They said, "They will have a 'sing song'. It might take them back to a period of time. It is a place for people to express themselves." We observed a number of people participated in an afternoon music therapy session where they engaged with the group and the people who were running the session. A visitor told us, "[Person] loves the music time."

People were encouraged to maintain relationships with people important to them such as their family and friends. We saw visitors arriving at the home during different times of the day. One visitor supported their relative to eat.

We noticed on one unit some people were having difficulty to eat the roast potatoes because they were crispy and not cut into manageable sized pieces. Staff did not notice this but a visitor did. They assisted one person by cutting up their potatoes and they gave them a spoon in place of a

Good

Is the service responsive?

fork so they could eat independently. We also noticed on this unit that the television and music was both on at the same time which did not promote a relaxing environment over lunch.

People told us they knew how to raise any concerns if they needed to and would not hesitate to speak with staff or the registered manager. Information about how to raise any concerns was also available in people's rooms. This contained information about who to approach. We asked a staff member how they would respond if someone raised a concern with them. They told us, "It depends if I could resolve the complaint. If it is quite simple I could sort it out. If it was more major then I would pass it on to the nurse or the manager." A relative who had made a complaint told us "[Registered manager] had investigated it right away." They confirmed they were happy with the outcome. Written complaints managed by the service had been fully investigated and taken seriously. Records indicated complaint outcomes were to people's satisfaction, however, the responses were not always formalised in writing. This was discussed with the manager for future review. Learning was taken from complaints and this was communicated to staff individually within supervision meetings or in group supervision.

Good

Is the service well-led?

Our findings

People were positive in their views of the home. One person told us, "On the whole I have always been satisfied, the room is cleaned every day." A visitor told us, "I would say it is well run. It is a nice place. [Person] is happy here." People were asked their opinions of the home through quality surveys, 'resident' meetings and suggestion cards. There was evidence the outcomes of the quality satisfaction surveys resulted in improvements within the home. One person had asked for subtitles on the television in the lounge and this was in the process of being organised. People and visitors were encouraged to post suggestions on how the service could improve. There was a notice board by the manager's office which displayed suggestions made and the actions taken to address them. This showed people's views and comments were taken seriously and acted upon.

During our visit we found staff to be friendly, co-operative, open and willing to talk to us. They were polite and friendly to each other and told us that they worked well together. Staff described a culture of openness. One staff member told us, "I would not hesitate to challenge any member of staff who I felt was not caring for a patient in an appropriate manner." Staff spoke positively about the home and told us they enjoyed working there. Comments included: "It is a good place to work." "If I had to have someone come here from my family, I would be happy." "The care is good, staff try to do their best and the managers know any areas we need to improve, they are proactive."

Staff told us they had regular meetings where they discussed issues relating to the home. They told us they felt suggestions they put forward were listened to. Comments included, "We have unit meetings and then you have the overall staff meetings." "We have regular staff meetings. We discuss the unit, the plans for the future, what needs to be changed and any issues." Night staff told us it was difficult for them to sometimes attend meetings but they did receive verbal updates during the 'handover' meetings held at the beginning of their shift. Staff told us 'handover' meetings held at the beginning of each shift enabled them to communicate any areas of concern as well as agree any measures to manage these.

There were good management systems in place with clear lines of reporting. On each unit there was a care manager or nurse that care staff reported to. The care manager or nurse oversaw the organisation of each unit. There was also a 'tissue viability' link nurse employed by the service so they could provide specialist advice to the nurses in wound management.

Staff were clear about their roles. One staff member told us, "My role is clear, if I don't know something my colleagues will help me." Staff told us the support they received from senior staff and the management team was good. Comments included: "Fantastic. The communication is very good. We are a good team." "We have good management. If you have any problems they will come in and sit with you. They make you feel confident so you can do your job even better."

The registered manager and deputy manager carried out a range of quality checks as part of a system to assess and monitor the quality and safety of care and services provided. This included care plan audits and medication audits to make sure they gave an accurate and clear reflection of a person's care and how they received support. The registered manager and deputy manager told us they regularly walked around the home to identify if there were any concerns about people, staff or the environment. Staff told us when the manager's did their walk around the home they provided them with information about people admitted or discharged, anyone who had fallen and other essential information such as people with pressure ulcers so they had an overview of the service and needs of people.

The registered manager had ensured when people were involved in accidents or incidents such as falls resulting in injuries, they informed us through statutory notifications as required. They told us accidents and incidents were monitored by the provider so they could check any on-going concerns were being acted upon.

The registered manager was responsible for providing quality monitoring information about all aspects of the business to the provider. This meant the provider played an active role in quality assurance and ensured the service continuously improved. We noted action had been taken following our last inspection to ensure the areas needing improvement were addressed. These were in relation to medicine management and the completion of accurate and up-to-date care records.