Roseberry Care Centres GB Limited

Lowgate Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The unannounced inspection took place on 20 and 25 January 2016. We last inspected Lowgate Care Home in May 2014. At that inspection we found the service was meeting all the regulations that we inspected.

Lowgate Care Home provides residential and nursing care for up to 42 people, some of whom are living with dementia. At the time of our inspection there were 37 people living at the service.

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

We found some shortfalls in the upkeep of the building and the premises. We found areas that needed to be updated, particularly in line with best practice with regards to people living with dementia and items of furnishing in need of replacement.

Medicines were safely managed and staff were knowledgeable and suitably trained. We did find areas where improvements needed to be made and we discussed this with the registered manager and have made recommendations.

People told us they felt safe in the home. Staff had received safeguarding training and were able to describe how they would respond if they had any concerns.

Accidents and incidents were recorded and monitored and risks had been assessed. Actions had been completed to reduce the likelihood of risks occurring.

We found staff were suitably trained and received supervision and appraisal from their line manager or registered manager. There were enough staff to meet people's needs and staff were able to respond to people quickly. Safe recruitment procedures had been followed to ensure staff were suitable to work with vulnerable people.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' it also ensures unlawful restrictions are not placed on people in care homes and hospitals.

Staff at the service supported people well with nutritional and hydration needs. People were happy with these arrangements and told us they received a variety of food tailored to their dietary needs to ensure these needs were met and maintained.

People told us staff look after them well. Staff spoke with people in a caring and kind manner and treated them as individuals with respect and dignity. People's care needs were detailed, recorded and reviewed by staff with input from the person, their families or healthcare professionals.

People had choices in their day to day living and were able to participate in a wide range of activities. Staff encouraged and supported everyone to maintain social links. People and their relatives told us they knew how to complain and any issues had been dealt with quickly.

We found suitable checks and audits were in place and these were completed by the registered manager and the provider. These were completed regularly to monitor the quality of the service. The registered manager had sent us notifications of incidents in line with their registration.

Staff felt supported in a team that worked together for the benefit of people living at the service.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to premises and equipment. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

We found some shortfalls in the upkeep of the building and the premises and have required the provider to take action to correct these.

Medicines were managed well, although we have made a recommendation to support this.

There were enough staff to meet people's needs. Safe recruitment procedures had been followed to ensure staff had suitable qualifications and experience to carry out their role.

Is the service effective?

Good

The service was effective.

Staff told us that they felt well supported and supervision and appraisal arrangements were in place.

Staff were following the principles of the Mental Capacity Act 2005. Deprivation of Liberty Safeguard applications had been sent to the local authority to authorise in line with legal requirements.

People's nutritional needs were met and they were supported to access healthcare services.

Is the service caring?

Good

The service was caring.

People told us staff looked after them well. We overheard kind words being spoken between staff and people and we saw people being treated as individuals with respect and dignity. This was recognised by people within the services and visitors alike.

Information was presented to people in a manner which enabled them to make day to day decisions about their care.

People and their relatives felt involved in the service and how it

operated.

Is the service responsive?

Good

The service was responsive.

Care records were personalised and contained clear information about how staff should support people. Assessments had been carried out to determine people's needs and were regularly reviewed.

There was a range of activities on offer at the service. We observed some of sessions organised, which people seemed to engage with and enjoy.

Complaints procedures were available and people and their relatives knew how to complain.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place and people, relatives and staff spoke highly of them.

The registered manager and provider carried out a number of audits and checks to monitor all aspects of the service and acted upon any issues they found.

Staff told us that they enjoyed working at the service and morale was good with incentives in place for staff who worked well.

Lowgate 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 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 20 and 25 January 2016 and was unannounced. The inspection was carried out by one inspector, one bank inspector and one specialist advisor. The specialist advisor had a background in nursing.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the home, including the notifications we had received from the provider about deprivation of liberty authorisations, serious injuries and deaths. We also contacted the local authority commissioners for the service, the local Healthwatch and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used their comments to support our planning of the inspection. On the day of our inspection we spoke with a GP who was visiting the service and a student nurse.

We placed posters in the main reception area to alert visitors that we were inspecting the service and would like to speak with them if possible. The posters had the name of the inspector responsible and contact numbers if anyone wished to contact us at another time.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with ten people who used the service and nine family members/carers. We also spoke with the

registered manager, two nurses, two senior care staff, one maintenance staff member, one cook, one activity coordinator, four care staff, one member of domestic staff and one member of laundry staff. We observed how staff interacted with people and looked at a range of records which included the care and medicines records for 10 of the 42 people who used the service and five staff personnel files. We also looked at health and safety information and other documents relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

When we asked one member of care staff if there was anything they would change or improve upon with the service, they said, "Nothing on the care side, maybe the building." Other staff we spoke with said that the premises needed, "An injection of money"; "Money spent on the décor "and "decorating and updating." We noted that a number of windows were in need of replacement. One of the maintenance staff told us it had been reported and the registered manager confirmed this.

When we inspected the outside of the building, we noted that some of the pathways which people could use were uneven and posed a risk of falls. We saw that paving at the entrance into the dining area was in a better condition than some of the other areas. Staff told us (about this area), "It is used for people to go out for a smoke, and is used the most."

Radiator covers were in need of replacing as they were not appropriate to protect people fully from risk of harm as they were the old metal type. The registered manager confirmed that these were on order and were due to be delivered in the next few weeks.

We noted that some corridors and rooms were faded and dull with worn furniture and carpets in places. We noted two chairs with rips in the fabric and a number of drawers where facia were loose and very worn. Contrast, colour and good lighting are recommended in good practice guidance for people living with dementia and we found this was not always the case. The registered manager was aware that work needed to take place and was waiting for the provider to confirm the dates for this as part of their normal refurbishment plan.

These issues are a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The maintenance staff were commended by the registered manager and staff on the work that they did. We spent some time with one of the maintenance staff and found them to have a good understanding of the people living at the service and how to keep them safe. They were clearly dedicated to providing a good standard of work to the provider which they knew would ultimately benefit the people living there. A range of checks on the safety of the premises and equipment were carried out, including five year electrical checks, gas safety checks and a range of monitoring checks on the fire safety procedures.

People told us they felt safe. We asked one person if they felt safe, they said, "I do. The staff could not do more. I wondered how I would manage at home on my own but since being here, I don't worry now." Other people we spoke to confirmed they felt the same. One relative told us, "They weren't safe where they used to live, but here – definitely."

Staff were trained in safeguarding vulnerable people and whistle blowing procedures and the staff we spoke with had a good understanding of the terms and what they needed to do, should they have any concerns. Relevant polices were in place to support staff with any procedural matters. One care staff member said, "I

would report anything like that. It's disgusting to think someone that is paid to care, could do anything like that."

Emergency procedures were in place and staff had received training and undergone practice drills. For example, everyone living at the service had emergency evacuations plans in place and the service had a contingency plan. Both were in place in the event of an evacuation from the premises due to a fire occurring for example; and would give the fire service and the staff on duty instructions to help maintain the safety of people living at the service. Staff were knowledgeable when asked about fire safety procedures.

Assessments had been completed for any risks that had been identified, either with an individual person or with the environment. For example, falls risk assessments had been completed for anyone at risk of falls and where additional safety measures were identified, these were taken. For example, one person was at risk of falling during the night and staff had placed sensor pads in their room to alert them if the person got out of bed for any reason. This made sure staff were aware of their movements and could monitor this more closely. Other risk assessments completed, included those for people who used oxygen to ensure that safe practices were followed.

Accidents and incidents were fully recorded, actioned and monitored for any trends forming. These incidents were discussed in staff handovers and other staff meetings for any lessons learnt. The registered manager was very organised and showed us evidence of this.

A senior member of care staff explained, "I get on-going medication training with [location of pharmacy] Pharmacy." We confirmed through staff training records that staff had all received appropriate medicines training and had received yearly medicine competency checks with their line manager.

People were not hurried, forced or reprimanded if they refused their medicines, but where appropriate reminded of the consequences of their choices. We observed one person refuse their medicines and staff spoke with them in a warm and kind manner to try to encourage them, but when they refused again; staff took their leave and marked the refusal on their medicine administration record (MAR). We asked staff what would happen if the refusals carried on. They told us, "We would contact the GP and ask for a review."

Correct procedures were followed for the use of covert medicines. Permission for covert medicines was given by the GP after consultation with staff and the person's representative. This was then presented in writing by the GP, to keep with person's records and the MAR. We observed this occurring during our inspection when a local GP visited the service and authorised covert administration to take place with one person who lacked capacity and this was done in their best interests.

There was no evidence of the use of medicines to replace therapeutic intervention or to sedate people due to their behaviours which may have challenged the service. One member of staff told us, "We have techniques that we use to calm people when they get over anxious. We talk to them or distract them. That usually works."

Safe medicines practices were followed for the ordering and storing of medicines and for administering and disposal.

'As required' medicines were administered to people when they needed them. 'As required' medicines are used by people when the need arises; for example tablets for pain relief. We observed medicines being administered to people at various times during the inspection. We saw that people who could understand, were asked if they needed their 'as required' medicines. However, there was not always a protocol or

instruction in place with the MAR to give clear instructions to staff when these should be given. This is particularly important for people living with dementia and those unable to express themselves. We also noted that topical medicines (creams) were marked directly onto the MAR but not always signed for. It was explained that staff responsible for completing the medicines 'round' verbally confirmed with care staff if creams had been applied. Nothing was recorded when the activity occurred and this could have been completed by different staff members at different times during the day. We discussed these issues with the registered manager who said she would address them.

We noted that the provider did not hold medicines to be disposed of in a tamper proof container within a locked cabinet as per the NICE guidelines. NICE is an organisation called The National Institute for Health and Care Excellence. They provide national guidance and advice to improve health and social care.

We recommend the provider follows best practice guidance in the safe management of medicines.

One member of care staff confirmed there was enough moving and handling equipment at the service. They said, "We do quite well, we have lots of slings and equipment." When we asked one member of kitchen staff if they had enough equipment they said "It's quite good and [registered manager] does her best to get what we need." We observed that foot rests were in place for people using wheelchairs and that staff handled people using recognised moving and handling techniques when transferring people, for example, from wheelchair to other chairs in the lounge area.

We looked at four weeks of staffing rotas to establish if suitable numbers of skilled staff were on duty to support people's needs. We found that suitable numbers of staff were in place and confirmed that during the inspection by matching the number of staff with the rota in place. Call bells were answered within adequate timescales and no person we spoke with commented on having to wait excessive periods of time to obtain support from staff once they had called for them.

The provider's recruitment and vetting procedures related to the recruitment of new staff were appropriate and protected the safety of people who lived at the service. Checks on potential staff members' identification, work history, character and health were carried out before staff began work, including confirmation of suitability to work with vulnerable people by the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). One member of staff confirmed the provider completed appropriate checks before they were allowed to start work, which included DBS and reference checks. This showed the provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit and appropriately qualified to do their job.

Nurse personal identification numbers (PIN) were all valid and up to date. All nurses and midwives who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identifying number called a PIN.

The service was odour free and clean and tidy throughout. We noticed that staff had access to gloves and aprons throughout the service to help protect them and people from cross contamination or infection. We saw the service had received a rating of 5, on a score of one to five for food hygiene from environmental health officers for a recent inspection of the kitchen area. We also saw that signs were displayed to remind staff and visitors to maintain good hand hygiene and noted adequate hand sanitising gels were available throughout the service.

Good

Is the service effective?

Our findings

People and their relatives thought that staff provided effective care. One person told us, "They are very good at what they do. They look after me very well indeed."

Staff had received appropriate training and had good levels of knowledge and skills to be able to support people in their care. This included training in moving and handling, infection control and health and safety. We spoke with staff to confirm this and also checked staff personnel records and training records. One relative told us, "I have no issues. The carers are trained. There are some absolute stars amongst them." One visiting GP told us, "Generally I find the home excellent, the nursing staff are skilled and only seek our intervention when necessary. Communication with next of kin is very good, as is end of life care." We saw that a community nurse had provided additional training to the staff team for the use of syringe drivers. A syringe driver is a small, portable pump that can be used to give you a continuous dose of your painkiller and other medicines through a syringe.

One staff member told us they had three days of induction and had shadowed an experienced worker until they felt competent. One member of care staff said, "Training is on all the time and it's repeated. It's done by the manager and is hands on and she explains things." Another member of staff said, "We do on-going training. If you feel you are lacking the manager will try her best to get us up to date. I have supervision with the nurse and training is discussed." A third member of staff told us, "The training is more than adequate. [Manager] keeps a matrix in the staff room so we can see when it's due."

All staff had received regular supervision and annual appraisals from the records that we checked. One member of care staff said, "I have supervision with a senior and we discuss concerns, ideas and training." Staff told us they felt supported and regular meetings took place to allow them to discuss best practice and to communicate with each other about issues within the service or the people living there.

A small number of people at the service suffered from pressure sores, some of which were in place when people moved into the home from other services. Pressure sores are areas of damaged skin caused by staying in one position for too long. One person at the service had a pressure sore which was healing well. The wound was being monitored and reviewed regularly by staff. The person had the correct type of mattress to support the healing process and staff ensured the person moved between areas to try and combat the possibility of further pressure areas forming. A tissue viability nurse was available to support any person with this type of wound. Other people who were at risk of skin damage, were monitored regularly by staff for any possible damage occurring. This all meant that people at risk of pressure sores or those who had developed one, received appropriate responses and care.

People had access to a range of other healthcare professionals should a need arise. We saw that people had been referred to GP's when they were not well and other people had been referred to occupational therapists or consultants for other health issues that had arisen. For example, one person had been receiving additional support from the community mental health team because of their diagnosis of a dementia related condition.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that where a best interest decision had been made, a variety of relatives and healthcare professionals had been involved.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Livery Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There were two people who had been authorised by the local authority to be deprived of their liberties. Records confirmed that the provider had met their responsibilities. Relatives, GP's and social workers were involved in the decision making process. The registered manager kept these applications under review to ensure no changes were needed and any future applications could be made in a timely manner.

One person told us, "It's good, cannot grumble. They do some lovely roast dinners." Another person said, "My favourite is the puddings. I have a sweet tooth." One relative told us, "The food is good and homemade and they always have a choice." Another relative told us, "It seems quite adequate and residents seem happy with what they receive."

We watched one person being supported with their mid-day meal in the lounge area. The member of care staff gently woke the person up and said, "Would you like some lunch, it looks nice." The member of care staff gave the person time to wake up and patiently sat and assisted them to eat. The staff member explained what the meal consisted of and the person was given a special cup to support them to drink. A further member of care staff approached another person, bent down and said "I've got you some juice [person's name], cranberry juice, you like that don't you? Can you put the cup to your lips?"

Kitchen staff had produced a range of four weekly menus. We spoke to the cook who was very knowledgeable about the people living at the service. They showed us how they appropriately monitored people's allergies and dietary needs. We asked who was currently on a special diet and they were able to show us a list of people. For example, those who were on a soft pureed diet and those who suffered from diabetes. Diabetes is a metabolic disorder. This is where the pancreas doesn't produce any insulin, or not enough insulin to help glucose get into the cells of our bodies.

Risk assessments were in place for people who had difficulty eating or swallowing their food. This ensured that staff had written instructions to follow to further support people at risk. Nutritional assessments had been completed to monitor people who were at risk of malnutrition with input from the Speech and Language Therapy Team (SALT). The SALT team offer expert assessment and management of communication and swallowing problems associated with ageing.

Through evidence and conversations it was clear that people were supported to eat and drink and maintain a healthy balanced diet, with any issues relating to nutrition and hydration being addressed. We noted, however, that some people were brought into the dining room and left waiting for excessive amounts of time (up to 20 minutes), while staff served others. We spoke to the registered manager about this and they acknowledged our comments and said they would look at better ways of serving meals to ensure that this does not happen.

A retro lounge and reminiscence room had been set up to provide additional stimulation and support people, particularly those with dementia related conditions. We noticed that not all bedroom doors had people's names in place, although none of the people with dementia related conditions had door names missing. We spoke with the registered manager about this and they said that all doors should have names on them. There was some signage in place to support people to orientate themselves around the building.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were very caring. People appeared to be content and well cared for. One person told us, "I like to belong and am happy to chat, it is so nice to be here and have visitors." A visiting GP told us, "Local people, including those who attend my surgery, speak highly of this home and I recommend it myself to those seeking placement as I believe it provides very good care." One staff member told us, "The atmosphere is homely and relatives speak highly of the place."

People told us their relatives or friends could visit when they wanted to. One person told us their relative visited regularly, sometimes at different times and days. They also told us staff were very happy to welcome relatives or visitors at any time. The relatives we spoke with confirmed this was the case.

We overheard staff speaking with people in a courteous manner and giving reassurance that what they had done for the person was no bother to them. For example, one carer said, "You're very welcome." After they had brought the person a drink of juice and had been thanked for it. One member of care staff told us, "We get the job done but don't rush anyone. It's always gentle and nice. Clients are a nice bunch of people."

One person was unable to communicate verbally but used facial expressions and eye movement to indicate particular responses to staff. One member of staff told us, "We know when [person's name] is happy with what's been asked, although it's difficult for them." We heard staff explaining to people what they were about to do, before performing the task. For example, we overheard the conversation between two care staff as they prepared to hoist one person from a wheelchair into a chair situated in the lounge area. We heard them asking if it was okay with the person to move them, asking if they could place the hoist strap around them and throughout the transfer they reassured the person.

People were treated with respect and given privacy when it was needed or asked for. One member of care staff was overheard quietly and sensitively asking one person in their bedroom, "Will we get you ready. Is that okay?" One relative said, "They are so respectful and good with [person]." Staff were seen knocking on bedroom or bathroom doors and waiting for a response, when they were about to support people with a particular task.

Staff helped people to retain their dignity and the registered manager reminded staff of the importance of this in their day to day work. We saw minutes of meetings where the registered manager had prompted staff of the importance of retaining people's dignity and asked that staff ensure curtains and doors were closed when performing personal care and that they only expose the part of the body being cared for when performing a particular task. We noted that there was also a dignity champion appointed at the service. Their role was to ensure best practice was followed by all staff and communicate between the staff team on a regular basis.

There were quiet rooms which relatives could use if they wanted to discuss an issue in private. We saw one family go into a private space to speak with one of the care staff about their relative who had been poorly that day. This meant staff were aware of the need to maintain confidentiality.

People were encouraged to remain as independent as possible. One person told us they liked to keep their room tidy and helped to do this where they could. We overheard one person being encouraged to brush their hair by one staff member. The staff member said to them, "I know it's difficult, but you're doing such a good job – that's beautiful."

No one was receiving the services of an advocate; however, information was available in the foyer if that level of additional support was required. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Good

Is the service responsive?

Our findings

People told us they felt involved with their care and were treated as individuals, and relatives confirmed this. We saw records which recorded people and their families or supporters had been asked detailed information about their health and personal history, including information about their families. This ensured that staff had personalised detailed information about people and were able to be more responsive to their needs.

Care plans and assessments were detailed and specific to the person receiving care. Pre admission assessments had been carried out with people and their families to determine their needs and the support they required from staff. A range of assessment tools had been used to determine what staff input people needed with mobility, nutrition and skin integrity. Where needs had been identified, care plans described to staff how they should deliver people's care.

During our inspection we overheard one person who told a staff member they didn't feel well. Staff responded to this person straight away, asking if they wanted to go to their room for a rest. Staff alerted the nurse on duty who checked the person to see if they could ascertain what was wrong. We spoke with this person's relative when they visited later in the day, they said, "I visit regularly and the staff are so good. They keep me updated because [My relative] is not too well, but they are looking after her so well. She is happy here."

Numerous activities were publicised on notice boards throughout the service and a list was produced detailing each months activities. For example, there was a "Burns afternoon" coming up in the next few days. Church services were also displayed and one was due to take place on the day of our inspection. We confirmed this took place as described. One relative confirmed that the service provided activities for the people who lived at the service and said, "They have church visitors, cookery theme days, entertainers and music. [Staff member] always makes sure the home is decorated for events." We noticed that magazines and newspapers reflected the rural area in which the service was located and included, "Farmers Mart"; "Hexham Courant" and nature publications. One staff member told us that other activities had taken place, including, "Puppets, a winter fayre and always music."

The registered manager explained that many people at the service enjoyed watching the birds that came into the gardens surrounding the service. They said a camera and bird box had been put in place to monitor any nesting activity in spring time and this was watched via the television in the dining room. We went into the garden areas and confirmed that staff had placed a camera within a bird box and also placed numerous bird feeding stations throughout the garden areas to allow people to watch birds feeding all year round. One person told us, "I love watching the little tits, they are so busy pecking away - they don't even notice me." One member of care staff said, "Some of the residents love watching the birds. We did not have much success last year with the camera, but we are hoping this year will be better with maybe some eggs for people to watch hatch!"

Many compliments had been received. Comments included; "Thank you all so much for looking after

[relative name]. You are all fabulous" and "The care at Lowgate is outstanding. I could not recommend it more highly. All staff genuinely cared about residents and their families and we are truly grateful for all they are doing for my [relative's name]."

People and their relatives confirmed they knew how to complain. Complaint policies were on display throughout the service for people to refer to if they needed. Eight complaints had been received since our last inspection. We looked through these and found that all of them had been investigated by the registered manager within appropriate timescales and correct actions taken. These actions had included investigation by the police and referral to the local authority safeguarding team when this action was necessary to follow correct procedures and ensure the issues had been dealt with correctly, which they had.

People had choice. One carer asked a person, "Would you like tea or coffee?" When the person said "No", the carer said, "Would you like water". The person responded positively and the carer returned with a glass of water. We looked at daily menus and noted that people had been ticked on a preference form as selecting a particular meal from the choice that was offered. We asked staff how this worked and one member of care staff said, "They [people] can choose from a list that the kitchen prepares. If they [people] don't want something though, there is a choice." We noted from records that one person did not like mashed potato. We saw at lunch time that most people had mashed potato with their meal, but this person had whole boiled potatoes.

Good

Is the service well-led?

Our findings

A registered manager was in post. The registered manager was present during our inspection and assisted us with our enquiries. The registered manager had worked at the service for a number of years and had a background in nursing. People, their relatives and staff spoke highly of the registered manager. They told us she was available to speak with them whenever they needed to.

Comments from staff included; "We have a good reputation. It's a nice place to be. We have everything we need"; "We have a good team and we get on really well. There is never a bad atmosphere"; "The manager is nice, you can ask her anything" and "The manager is really good. Very easy to get on with. Moral is good." A healthcare professional told us that the registered manager "ran a tight ship" and added, "I am always made to feel welcome, staff communicate very well, good care."

The registered manager operated an 'open door' policy. We saw evidence of this when we inspected the service and watched relatives and staff visiting the registered manager to ask questions or ask advice. The registered manager never gave the impression she was too busy to see anyone. One relative told us, "I have recommended this home. There are smarter places but the care here is very good."

The registered manager told us, "I have a good bunch of staff here. They all work hard to keep standards high." In the staff room, there was a range of material available for staff to read, including health and safety information and whistleblowing procedures.

The registered manager had set up a number of staff 'champions' to take the lead on particular issues. For example, we noted that a summer heat wave champion had been appointed and their duties included monitoring room temperatures, checking headwear was worn outside and monitoring fluid charts with the purchase of ice lollies when required. One staff member told us, "It's not often we have hot weather, but when we do, it's good to have someone like that on the team."

Staff incentives were available. These included a new incentive for staff who had not been off work sick. They would be placed in a prize drawer and the winner would be chosen to receive a gift voucher or other award. The registered manager also told us that they had another scheme in place, called a 'morale booster'. This was a scheme to incentivise the staff with small gifts and the staff member was chosen by people and their relatives because of a piece of outstanding work or dedication they had performed.

People and relatives were included in the running of the service. Six to eight weekly meetings took place with people and their relatives to enable them to participate and discuss items of information, change or concern to them. We noted in one recent meeting that a range of topics had been discussed and this included, activities, visits and kitchen and food issues which had included a conversation about puddings and overcooked vegetables. The minutes generally included the responses made to the comments noted, which meant that action was taken to any issues arising. We spoke to one person about the issue of overcooked vegetables. They told us, "Some people might like complaining. I find the vegetables are fine."

Suggestion boxes were available in the reception area. We also saw that the registered manager had sent out surveys to people and their relatives, healthcare professionals and staff and these had been analysed and the results were available within the service for everyone to see. On the notice board it stated, "You have identified that we have a small issue with identification of clothing items." We asked the laundry staff how they dealt with this issue. They explained the procedures that were in place and the additional measures they had implemented to try and ensure this did not happen. They said, "If we see an item of clothes without a name, we try to find out who it belongs to and most times we can, and just add the name ourselves, but sometimes we cannot and that is when it is hard."

A range of audits and checks were completed by the registered manager and the provider. These included regular checks on people's care records to ensure all information was present and correct. Medicine audits were completed by the local pharmacy and also the service on a regular basis and included comments from people on their views around medicines. One person was recorded as being "happy with the management of medicines." The registered manager also completed regular health and safety inspections with staff supporting them. These included, checks on the maintenance of the building, checks on the administration of the service and checks on the housekeeping.

The provider had not updated some of their policies in line with their normal review process. We found the medicines policies had not been reviewed since 2012, although the registered manager had noted that they reflected current practice in 2015. The registered manager said she would pass our comment on to the provider.

Staff at the service worked in partnership with other agencies or services. The registered manager communicated well with the local authority safeguarding team when a safeguarding issue had occurred. Staff at the service worked well with other organisations to promote the wellbeing of people at the service, including the community mental health team and district nurses.

The registered manager and the provider had ensured that statutory notifications had been sent and that the requirements of their registration had been met.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured that people were protected against the risks associated with unsafe or unsuitable premises. Regulation 15 (1)