LJ Care Homes Ltd

York House

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

The inspection took place on 25 and 26 April 2018 and was unannounced.

York house is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. York House accommodates up to 16 people who need care due to old age, dementia, physical disabilities or sensory impairment in one adapted building. There were 14 people living at the home on the day we visited.

The provider also provides a domiciliary care agency which it promotes under the name LJ Home Care. It provides personal care to people living in their own houses and flats in the community. It provides a service to people who need care due to old age, dementia, physical disabilities or sensory impairment. Not everyone using the service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. There were 17 people using the homecare service on the day we visited.

There was a registered manager for 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.'

At the last inspection the service was rated as requires improvement at this inspection we saw that the provider has made improvements and the service was now rated as good.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Checks were completed before staff started to work at the service to ensure they were safe to work with vulnerable people. There were enough staff to meet people's needs and people who received care in their own homes were provided with a consistent group of staff who knew their needs to support them. Staff received training and support which supported them to provide safe effective care. There were good relationships between staff and other healthcare professionals and we received positive feedback about the care from healthcare professionals.

Risks to people were identified and care was planned to keep people safe while receiving care or in an emergency. Medicines were safely managed and available to people when needed. Infection control processes kept people safe from the risk of infection. However, we recommend that the provider follow the national guidelines on the use of different coloured cleaning cloths in each area.

People were offered a choice of food and staff monitored people to ensure they could eat safely and had enough to maintain a healthy weight. People told us that the staff were excellent. They told us that they were kind, caring and put the needs of the people at the centre of everything they did. People had been involved in developing their own care plans and we saw that care plans contained the information needed to provide safe care tailored to people's individual needs. People and their relatives received compassionate care at the end of their lives which ensured they were comfortable and had people around them.

The registered manager was open and inclusive and people, relatives and staff felt comfortable raising issues with them. Audits monitored the quality of care provided and external expert audits were also used to drive improvements. If any issues were identified action was taken quickly to resolve the concern.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had received training in keeping people safe from abuse and knew how to raise concerns.

Risks to people had been identified and care was planned to keep them safe.

There were enough staff available to meet people's needs.

Medicines were safely managed.

Staff had received training in infection control and knew how to work to keep people safe from cross infection.

Incidents were analysed and action taken to prevent similar incidents reoccurring.

Is the service effective?

Good

The service was effective.

The provider kept up to date with national policies and best practice guidelines.

Staff received training so that the care they provided was safe and met people's needs.

People were supported to eat and drink safely.

Staff worked collaboratively with other healthcare professionals to meet people's needs. People were referred for healthcare when issues were identified.

The environment supported the needs of people living with dementia.

People's rights under the Mental Capacity Act (2005) were respected.

Is the service caring?

Good

The service was caring.
People received care from staff who knew them and their families well.

Staff ensured that people were happy and confident.

People could make everyday choices about their lives.

People's dignity was supported.

Is the service responsive?

Good

The service was responsive.

People had been involved in developing their care plans which ensured they reflected their individual needs.

People were supported to access the local community and to engage with activities in the home.

People received end of life care which ensured they were comfortable.

People were given information on how to make a complaint.

Is the service well-led?

Good

The service was well led.

People felt that the service was well led.

The registered manager was open and inclusive and gathered the views of people using the service, relatives and staff to drive improvements.

Audits identified concerns in the home and the registered manager to action to rectify any issues identified.

York House

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.

The inspection took place on 25 and 26 April 2018 and was unannounced. On the first day our team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day our inspector returned alone to complete the inspection.

In preparation for our visit we reviewed information that we held about the service. This included notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We used 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 the registered manager, a senior care worker, two care workers, the activities coordinator and a housekeeper. We spoke with a visiting healthcare professional. We also spoke with eight people who used the service and five relatives.

We looked at a range of documents and written records including six people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Good

Is the service safe?

Our findings

We found that people were safeguarded from situations in which they may experience abuse. Records showed that care staff had received training and knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk.

All the relatives told us that they felt their loved ones were safe with the staff. One person told us, "I am sure I am safe here, they are all so very kind and keep me safe I know. They come and see to you if you need any help and offer kind words to you and reassure you." A relative said, "I believe she is as safe here as she can be anywhere."

The registered manager had worked with the local authority safeguarding team to investigate any concerns raised about the care provided by the service. In addition, they had raised concerns themselves, when they were worried about people's safety. An example of this was the registered manager rising a concern when a person had been unsafely released from hospital into their care. The person had arrived at the home by ambulance in the middle of the night, even though they were not living at the home and not expected. They were taken in and made safe and comfortable for the night and the registered manager worker with health and social care professionals to resolve the concern the following morning.

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. Care plans contained the information needed to ensure that the care minimised the risks to people. For example, people's moving and handling plans had information about the type and size of sling to be used. People's slings were kept for their own personal use. People's risk of falling was identified and care was planned to keep people safe, for example, use of aids, increased monitoring and where needed sensory alarms to alert staff when people get out of bed. Risk assessments were also in place regarding use of equipment and pressure area care. Risk assessments had been reviewed monthly.

Staff had received training in fire safety and fire alarms were regularly tested. People living at the home had been assessed for their ability to respond in an emergency and information was recorded so that it would be available to the emergency services if needed. Personal evacuation plans were developed for people and these were left in an accessible place so they would be available to the emergency services if needed. Risk assessments were completed on people's own homes to ensure that they were safe for the people living there and the staff. The registered manager had developed a relationship with the local fire brigade so that were able to ask them to assess a person's home if they had any concerns.

The registered manager told us that they had carefully established how many care staff and other members of staff needed to be on duty. They said that they had taken into account the number of people they provided care for and the needs of each person. Staff told us that they had time to meet people's needs and did not feel rushed. A person living at the home told us, "If I need to press the buzzer, they come very quickly." A member of staff providing care to people in their own home told us that they had enough time at each visit to complete the care required. They told us that the call schedule allowed them to spend more

time with a person if they needed to. They explained that the ethos of the service was that people who received care came first.

There were risk assessments in place to monitor staffing levels. The registered manager could be flexible to meet people's needs. For example, if anyone was sick and needed more care the registered manager would arrange for extra staff to be on duty. The registered manager told us that when looking at providing care for people in the community they were careful not to take on anyone whose care needs they could not meet. In addition, they would only agree to provide care for people if they were sure they had enough staff to be able to meet the time and consistency of staff which would support good care. At present there were only four members of staff providing care for people in their own home. If needed, staff working in the home were able to cover the calls when community staff took their holidays. The registered manager told us that they liked to keep the same staff members caring for people living in the community as this helped people to receive a quality service. In addition, the registered manager told us that they would leave a gap between care calls so staff had time to take care of any unforeseen problems.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

We found that suitable arrangements were in place to safely order, administer and dispose of people's medicines in line with national guidelines and accurate records were kept. Medicines were monitored and stock counts completed daily. Monthly audits were undertaken to ensure people's medicines were available to them and had been administered in line with prescriber's instructions. Any concerns found were investigated and where needed action was taken to keep people safe. People were happy with the way their medicines were managed. One person told us, "My medication is always given to me when I need it."

Staff received training in administering medicines and were observed to ensure they were competent before they were allowed to administer medicines. Care plans contained information about people's medicines and why they were taking them. Care plans clearly indicated the reason people needed support with their medicines and could no longer be independent with them. The care plans for people who received care in their own homes contained clear information about the level of support they needed around medicines. For example, some people needed reminding while others needed them administered. There was also information on who was responsible for ensuring the medicine was available. Staff were clear that they would raise concerns with both the office and the GP if a person refused to take their medicine as prescribed.

Some people had medicines, such as painkillers prescribed to be taken 'as required'. We saw that staff had a good knowledge of people's needs and abilities around medicine. They knew who could request pain medicines and who they needed to monitor for signs of pain. In addition, protocols were in place to support staff to make the decision f they should administer 'as required' medicine

Medicines were administered safely Side effects of medicines were noted and considered if people's behaviours changed following a change in medicines. For example, staff had access to a list of medicine which may increase a person's risk of falling. One person at the home was having their medicines crushed. We saw that staff were aware of the issues around crushing medicines and had contacted the pharmacist for advice before crushing any medicines. This was important because some medicines can be altered by crushing and may be absorbed too quickly or may be dangerous for staff to handle.

There was no one at the home who self-medicated. However, there was a policy in place along with an assessment toolkit. This meant that if anyone admitted to the home wanted to administer their own medicines the systems were in place to support this.

We found that suitable measures were in place to prevent and control infection. There was a cleaning schedule in place and the home was clean when we visited. The cleaner could tell us how they worked to reduce the risk of infection, which included different cloths for each area they stored the clothes in a certain area of their cleaning caddy so they knew which to use for toilets and which were for cleaning other area. However, they were not using different coloured cloths in each area in line with national guidance, so there was a risk they would mix up the cloths. While there had been no infections in the home recently, we recommend that the provider works in line with the national guidance on using different coloured cloths in each area to reduce the risk of any confusion.

Two members of staff attended the local authority infection control meetings to keep up to date with infection control concerns. We saw best practice was in place as each room had hand wash, alcohol gel and paper towels so that staff could wash their hands before and following personal care to reduce the risk of cross infection. Staff we spoke with were able to tell us what measures they took to keep people safe from infections. Examples they gave us included washing hands at regular intervals, using protective equipment like gloves and aprons, and correctly disposing of waste. In addition, they could tell us how they would support people with infections to keep it from spreading to others in the home.

We found that the registered persons had established suitable arrangements to enable lessons to be learned and improvements made if things went wrong. This included the registered manager carefully analysing accidents and near misses so that they could establish why they had occurred and what needed to be done to help prevent a recurrence. Accident forms had been appropriately completed and action had been taken to provide immediate care for people. For example, ambulance or healthcare professionals were contacted and when further action was needed to keep people safe. Risk assessments were then reviewed to see if changes could be made to the care provided. We saw an example where one person had been referred to the falls clinic and a sensor mat put in place to alert staff when they started to get out of bed.

Good

Is the service effective?

Our findings

We found that robust arrangements were in place to assess people's needs and choices so that care was provided to achieve effective outcomes. The registered manager would assess the needs of people before they moved into the home or provided care for the person in their own home. This ensured people's needs could be met and staff had all the skills and knowledge needed to provide safe care.

The provider had policies in place to support staff in providing care which met best practice. Staff were required to review these policies as part of the induction process and to keep up to date with any changes. When polices changed staff had to sign to say they were aware of the changes. This allowed the registered manager to ensure all staff were aware of the changes. Staff who provided care to people in their own homes told us that they visited the office once a week so that they could be updated by the registered manager on any changes in care or policy.

The registered manager had implemented best practice wherever possible. An example of this was that the staff had had completed 'Herbert protocol sheets' for people they thought may try to leave the home. The Herbert Protocol is a national scheme being introduced which encourages both paid and informal carers to compile useful information which could be used in the event of a vulnerable person going missing. A form recording all vital details, such as medication required, mobile numbers, places previously located, a photograph had been put in place for people. This meant in the event of a person going missing, the form could easily be handed to the police reducing the time taken in gathering this information.

Relatives we spoke with told us that the staff had the skills needed to meet people's needs. One relative told us, "Yes my wife and I think she is safe as possible here and far better than she was at home without any doubt. They seem well trained and confident at looking after and taking care of people." Another relative said, "I think the staff are trained well and I know they have to do training for all sorts of things."

Records showed that new care staff had received introductory training before they provided people with care. New staff had to bring in their training certificated from other providers and a training programme was set up to cover any areas where they had not already completed training. Staff who had not worked in care before were required to complete the care certificate. The care certificate is a set of national standards to cover the knowledge needed to provide safe care. New staff also shadowed an experienced member of staff so that people could get to know them and they could learn how people's care could be tailored to their individual needs.

In addition, staff had also received on-going refresher training to keep their knowledge and skills up to date. The registered manager had a training plan in place for 2018. It covered subjects that would support staff to provide safe care. For example, it included training in supporting people to move safely, dementia and the Mental Capacity Act (2005). The registered manager and provider had supported staff to undertake nationally recognised qualifications in care.

Staff told us that they received regular supervisions with their line manager and had an annual appraisal to

discuss their career and any extra training they would like to complete to help them progress in their careers. In addition, as the service was small the staff spoke with the registered manager every day and raised concerns as they occurred.

People told us that they were happy with the food provided in the care home. One person told us, "We have lovely home cooked food and even have proper fish and chips from the local chip shop every Friday lunchtime." We saw that at lunchtime the cook was making up some meals in foil trays. They explained that these were for some of the people who received care in their own home and who could no longer cook a proper meal for themselves. This allowed the people to receive a hot meal during the day and supported their nutritional intake.

People's care plans contained the information needed to ensure they ate safely. For example, some people needed a textured diet. This is where food is either cut up small, mashed or purred and is needed when people are unable to swallow whole food safely. Where needed people had been referred to healthcare professionals for advice on the type and consistency of the food they could safely eat. Care plans contained specific information on people's behaviours around food if they presented a risk to them. For example, we saw that one care plan noted that the person should not be left with sweets as they would eat them and they were a diabetic. Another care plan noted that the person was to be offered food and drink separately as they would pour their drink over their food if the chance arose.

People's lunch was offered to them in a way that supported their independence. For example, one person had their lunch in a bowl so that it was easier for them to get the food onto their cutlery. We saw that one person who was sat at the dining table said little during the meal. We saw that staff kept a vigilant eye on them and offered them a second helping.

There was only one option planned for the main meal of the day, but people could ask for anything else they wanted and this would be cooked for them. The planned menu choices were set at the resident's meetings. Breakfast was also a free choice and people were able to request a cooked breakfast if they wanted. A relative told us, "Nothing is ever too much trouble for them. The other day I came and sat and one gentleman was eating some egg on toast. My dad was having cereal at the time. He said he thought how good it looked and so the staff went along and got him some egg on toast without saying a word to him. How amazing is that."

People were offered a choice of drinks throughout the day. We did not see anyone who was unable to eat and drink enough to stay healthy but staff were able to describe the steps they would take to support people. These included referring to the GP and recording their food and drink intake.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. Systems were in place to ensure that if a person went to hospital or moved to another home that the information about their medicines was available to the people who would be supporting them. Care plans contained emergency grab sheets so that all appropriate information was ready to hand over to other healthcare professionals in an emergency.

In addition, extra information was provided to ensure that the care could be tailored to an individual's needs. We heard a member of staff pass on details to the ward a person had been admitted to. The member of staff gave a good recent history of the person and their health. In addition, they passed on person centred information which would have helped the hospital staff look after the person and understand their abilities better.

Where necessary people had a GP admissions avoidance plan in place. This supported staff with the action to take if people deteriorated and helped them to look after people in the care home or their own home instead of them being taken to hospital.

Healthcare professionals told us that staff were proactive and that they were 100% confident that staff would follow any instructions they left. A healthcare professional told us that staff knew what signs to look for that may indicate a was person developing pressure areas. They said staff would contact them as soon as they identified a concern.

A visiting health care professional told us that if they arrived at a person's home when staff arrived to provide care that there were no issues. They said that staff worked around people's needs to deliver care in the person's best interest.

People told us they were supported to access healthcare. One person told us, "They call the doctor if needed, though I don't need him very often." Records showed that people were supported to access healthcare advice and support on an ongoing basis. For example, we saw that people could have their eyes tested and that they were supported to attend for any healthcare screening they were invited to. In addition, people were able to access care for a GP or community nurse when needed. Where people were living with conditions that may be more complex to manage, staff liaised with specialist nurses for guidance and support.

We found that the accommodation was designed, adapted and decorated to meet people's needs and expectations. The registered manager kept track of all the maintenance needed in the home and we saw that everything had been completed. For example, hoists had been serviced to ensure they were safe to lift people. The home was pleasantly decorated and attention to detail provided a good environment for people. For example, at lunchtime the dining tables were decorated with vase of fresh flowers, cruets, menus, napkins.

There was signage around the home to support people living with dementia to find their way around. Most of the bedroom doors had numbers and the name of the person on, along with a memorable picture to help people identify their own bedroom.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty 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. Staff had received training in DoLS and knew about ensuring people's choices were respected where ever possible.
Appropriate applications for DoLS had been submitted to the local authority for assessment. There was no one living at the home who had any conditions placed on their DoLS.

Where people could make decisions for themselves their choices were respected. People's abilities to make

choices had been recorded in their care plans. Where people may not have been able to make decisions for themselves assessments had been completed on their ability to make individual decisions. If they were unable to make a decision one was made in their best interest taking the views of family, staff and healthcare professionals into account. Care plans also recorded where people had legally appointed a person to make decisions in their best interest. Records showed the registered manager had completed best interest decisions when needed including for the administration of covert medicines or when restricting people by using bed rails. Covert medicine is when medicine is hidden in food so that the person does not know they are taking it.

Good

Is the service caring?

Our findings

People were treated with kindness and they were given emotional support when needed. Relatives we spoke with told us that they staff were exceptionally kind. One relative told us, "I come every day to visit and see and hear all sorts and I can honestly say how wonderful this place is. The staff are great and treat all the residents with dignity and respect and do everything possible to help and keep them safe and happy. They are lovely people and the staff know everything about the residents. They keep me well informed about my mum and when you ring up if they don't know; they always say Ill pop and find out for you." We saw that staff knew people and their needs in detail. We saw that staff adjusted their communication with each person to meet their needs. Care plans contained information about people's ability to communicate along with their social history. This helped staff to build caring relationships.

A visiting healthcare professional told us that the caring ethos was mirrored when staff provided care for people in their own home. For example, when one person had to move into a home the member of staff stayed and helped them to pack so that they had everything they needed. The registered manager told us that all staff were introduced to people before they provided care. This meant people always knew who was walking into their home.

Staff spent their breaks sitting in the dining area talking with people. We saw that these chats were enjoyed by people living in the home and staff and they spoke about their families, the local community and reminisced. We heard them reminiscing about one food and how once a year the local community got together and made this for people living in the village. The registered manager of the home brought her lunch and came and sat with the residents too and chatted.

Staff who provided care to people in their own home told us how they worked an agreed area and so would see the same people every day. In addition, when they were on leave the same member of staff would cover their calls. These arrangements ensured that people were supported by a consistent group of staff who knew their needs and could identify quickly if there were any changes or if the person was unwell.

Staff took action to ensure that people were as comfortable as possible when receiving care. An example of this was when the community nurses visited each morning to give a person their insulin injection for diabetes. Most days they had the same nurse and were happy but if a different nurse came the staff would stay with the person as they did not understand that the nurse was trying to help them.

The staff were aware of people's likes and how to encourage them to live each day to the maximum. For example, one person living at the home could become low in mood, but liked animals. The registered manager brought their pet dog in for the person to see and this encouraged them to get up in the mornings. In addition, the home had a cat and we saw that the people living at the home were fond of the cat and could encourage it to visit them for cuddles.

A visiting professional told us how staff supported people's friendships. They told us how a person who had been at the home for respite care had gone home. However, a person living at the home really missed them

as they had become friends. Staff supported the friendship by taking the person around to see them this also reduced the risk of social isolation to the person who had moved back to their own home.

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Care plans contained a good pen picture of people's needs and like and dislikes. For example, we saw one person's care plan noted that they liked to snuggle under a blanket, day and night regardless of the weather. In addition, their care plan noted that they needed encouraging to bath as they declined baths and would complain of being cold when in the bath. The home had two shared rooms. We saw that there were clear indications for why people chose to stay in a shared room. For example, one person's care plan noted that they moved to a shared room as they were frightened at night.

People's privacy, dignity and independence were respected and promoted. Staff wore name badges and there was a staff photo board in the reception area to the home identifying staff and their roles. This meant people with dementia were able to identify who was caring for them. Staff told us that they had received training in supporting people to maintain their dignity. They gave examples of keeping people covered with a towel while providing personal care and ensuring doors, windows and curtains were shut.

There was a tuck shop run by the people living at the home so that people could buy themselves a treats or toiletries. A relative told us, "I think the Tuck Shop is a great idea as it gives everyone some choice and independence." This meant people were able to be self-sufficient and did not need to rely on anyone to provide a few luxuries.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Good

Is the service responsive?

Our findings

We found that people received personalised care that was responsive to their needs including their right to have information presented to them in an accessible manner.

Care plans were focused around people's individual needs and identified the risks to people. For example, people's ability to mobilise around the home was noted. We saw care plans for people receiving care in their own homes provided all the information staff would need to provide safe care. Call times were recorded along with how long acall should be. Care plans contained information about at what care required completing at each call. People had signed their care plan to show they were happy with them. The daily notes that staff recorded about people's lives were complete and accurate. They allowed staff and visiting healthcare professionals to fully understand people's needs and health issues.

Staff we spoke with could describe the care people needed and this matched what was recorded in their care plan. For example, they told us about a person who while not distressed lacked focus while receiving their personal care. They told us how two care staff provided care for this person, one to distract them and the other to provide the care.

A relative we spoke with was full of praise for the care provided following a fall. They told us, ""She fell and broke her hip which was not anyone's fault but we have to praise the staff here for getting her back up on her feet again after she came out of hospital. They allocated two carers at first to assist her and to encourage and rehabilitate her. They were so nice and determined she would walk again, as was she! They fully supported her and she made it, most old people her age would have taken to their bed and would have been allowed to. Not here, they have done amazingly well with her."

Healthcare professionals told us that they had no concerns about the care provided in the home. They said that the care plans were excellent and that staff knew all about the care people needed. They told us that they liked to visit the home as it was very welcoming. They described the home as being very person centred and clarified this by explaining that they do whatever people want. Healthcare professionals told us that the staff were particularly good with people living with dementia and that they could distract and calm them when they became distressed. This skill by staff meant that the use of drugs to help people be calm was kept to a minimum. At the time of the inspection no one living at the home was using these drugs.

People showed us and records confirmed that they were offered the opportunity to pursue their hobbies and interests and to enjoy taking part in a range of social activities. One person said, "I change the colour of my nails every week. We do lots of things, if we want to. I get out when I can and get taken to the Co-op in the village, and to the community coffee morning on a Thursday. I like to dance and we often have music on and we get to have a dance if we want to.

We saw that after lunch the activities coordinator brought everybody into the sitting room for activities. They had a music sing along with each person in turn choosing one of their favourite songs and artists. Everyone engaged with the singing. One person who had not really engaged with anyone during the day became

animated when the music started playing and danced. The activities co-ordinator was attentive and knew people well. They encouraged and gently cajoled some people into getting up and dancing with her. The housekeeper came into the room once or twice during the sing a long and took the hands of people and danced with one of the gentlemen, who was happy to do this. He was smiling all the time and enjoying the dancing.

A variety of activities took place, some were fixed like the painting class on Tuesday. On a Thursday morning several people chose to go to the local coffee club and meet up with friends in the community. People were supported to maintain and practice their religious beliefs. Once a month there was a church service in the home. One person told us, "I had the vicar visit last week and it was nice to be able to take communion. "One member of staff explained how they used activities to talk to people and learn more about them and if there was anything they needed which would make them feel better. An example of this was one person who asked if their body hair could be shaved as they felt it was impacting on their ability to feel attractive.

Suitable provision had been made so that people could be supported at the end of their life to have a comfortable, dignified and pain-free death. Staff had received training in palliative care and the support people needed at the end of their lives. The registered manager and staff liaised with other healthcare professionals such as McMillian nurses to keep people comfortable and pain free at the end of their lives. They told us how they had also supported family members by talking to them about the care needed. Staff told us that they had time to spend with people at the end of their lives. And that the registered manager would ensure that a member of staff was available to sit with them anytime family members could not be present.

There were arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. People received information on how to make a complaint when they first started using the service. In addition, there was information on display in the care home and for people who received care in their own home information was available in the front of their care plans. Everyone we spoke with was happy with the care they received and no complaints had been received since our last inspection.

Good

Is the service well-led?

Our findings

We noted that the provider had taken a number of steps to ensure the service's ability to comply with regulatory requirements. There was a registered manager in post and the provider had displayed their rating in the home and on their website. The registered manager had notified us about events that had occurred in the home.

People were complementary about the care provided by the service and felt that it was well run. One relative told us, "We would give this place five stars, it's a fantastic place. As good as home." Another relative commented, "It's a fantastic place and the care is over and beyond. They just sort things and take away the worry. It's hard enough being a carer and looking after loved ones, and they just make you feel better about yourself." A person living at the home said, "The boss lady [registered manager] is very good and she is always here and talks to everyone and sits with us."

We saw that the registered manager had developed a culture where staff were expected to work together and cover each other if needed. The registered manager led by example and got involved when people were upset. We saw the registered manager reassuring one person as they felt their family was not visiting as often as they should. They reassured the person that their family had visited and refreshed their memory of the event. The provider visited the home twice a week and the registered manager told us that they were very supportive.

Staff who provided care to people in their own homes told as that they had great support from the registered manager and other office staff. They told us that if they had any problems they could ring the office for support and if needed office staff would go out and provide support for people. This flexibility meant that if homecare staff had an emergency, they could stay with the person as they knew other people's calls would be completed by office shaft in a timely manner.

There was a system of audits in place to monitor the quality of the care provided and to identify areas for improvements. These audits were effective and we found that people were receiving good care. In addition, the provider engaged with external organisations to receive feedback about their care and took action to rectify any concerns that were identified. For example, there had been a recent inspection by the local authority. They had identified concerns with the carpet being a trip hazard. The provider had arranged for new carpets to be laid and this work was being undertaken at the time of our inspection. In addition, a review by a community pharmacist had been completed in March 2018. We saw they had identified some areas of concern. We reviewed the concerns they had identified and found that the provider had taken action to ensure that they were working in line with the pharmacist recommendations.

We found that a number of systems were in place to help care staff to be clear about their responsibilities. Staff meetings were held every three months and the registered manager told us that they expected all staff to attend and they shared the minutes of the meetings. In addition, staff were able to speak with the registered manager at their three monthly supervisions. However, as the service was small and staff worked well together we saw that they were able to speak with the registered manager at any time and were

confident that they would be supported. The registered manager had developed and inclusive environment in the home. For example, staff were asked for their suggestions on how to spend the recent grant the home had received. Issues around privacy and dignity were discussed. Staff were able to request things to help them in their work. For example, we saw they had requested a new vacuum cleaner and some new soap dispensers.

We found that people who lived in the service and their relatives had been engaged and involved in making improvements. Records showed regular resident's meetings took place. Minutes showed that they had discussed activities and one person had suggested getting a greenhouse and the registered manager had arranged for one to be purchased. Food was also discussed, for example, some people suggested they would like teacakes on the menu and more salads during the summer. As people living in their own homes were more isolated the registered manager visited them on a regular basis to ensure they were happy with the care provided and did not want any changes. In addition, people had recently completed a survey about the care provided. The results were positive with no negative comments being received.

We found that the registered persons had made a number of arrangements that were designed to enable the service to learn and innovate. This included members of care staff being provided with written policies and procedures that were designed to give them up to date guidance about their respective roles. The registered manager had engaged in partnership working and had developed excellent working relationships with the local GP practice and community nurses. In addition, they had taken advantage of every opportunity to improve the lives of people. An example of this was the registered manager applying for and receiving a grant from the local authority to be used for the benefit of the people they support.