Shivron Care Home Ltd

Buttercup House Care Home

Inspection report

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Tel: 02380448982

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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

This inspection took place on 16 March 2017 and was unannounced. Buttercup House Care Home is a care home registered to provide accommodation with personal care for up to 20 people, including people living with a cognitive impairment. There were 13 people living in the home when we inspected.

At the time of the inspection the home was undergoing extensive building work and refurbishment to better accommodate the people living at the home.

Buttercup House Care Home did not have a registered manager, however the manager had commenced the process to register with the Commission. 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.

People and their families told us they felt the home was safe. Staff and the manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people, when necessary in a patient and friendly manner.

Staff developed caring and positive relationships with people and were sensitive to their individual choices, treated them with dignity and respect. People were encouraged to maintain relationships that were

important to them.

People received person centred care from staff who knew each person well, about their life and what mattered to them. The people living at the home experienced a level of care and support that promoted their health and wellbeing and aimed to enhanced their quality of life.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs.

There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service provided both informally and through quality assurance questionnaires. They were also supported to raise complaints should they wish to.

People's families told us they felt the home was well-led and were positive about the manager and provider who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

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.

The manager had assessed individual risks to people and had taken action to minimise the likelihood of harm in the least restrictive way.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

People received their medicines at the right time and in the right way to meet their needs.

Is the service effective?

Good

The service was effective.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important

relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

The manager and provider actively sought feedback from people using the service and their families.

There was a clear process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff.

People, their families, health professionals and staff had the opportunity to become involved in developing the service.

The provider was fully engaged in the running of the service.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

Buttercup House 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 16 March 2017 and was unannounced. The inspection was undertaken by one inspector.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with three people living at the home and engaged with four others, who communicated with us verbally in a limited way. We observed care and support being delivered in communal areas of the home. 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 four family members following the inspection via telephone. We also spoke with the directors, the manager, four members of the care staff, the cook and two visiting health professionals. We looked at care plans and associated records for four people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in August 2015 when it was rated as 'Requires Improvement'.

Good

Is the service safe?

Our findings

At the previous inspection, in August 2015 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Risks to people were not always assessed and mitigated appropriately. The provider wrote to us detailing the action they would take to meet the regulation. At this inspection, we found action had been taken and the provider was meeting the requirements of this regulation.

The manager had assessed the risks associated with providing care to each individual. Each person's care file contained robust risks assessments which identified the risks along with the actions taken to reduce these risks. Risk assessments in place including; falls, nutrition, skin breakdown and moving and handling. One risk assessment described how to provide personal care to a person that posed a risk to themselves or others. The risk assessment stated, 'During heightened anxiety make sure the person is safe, leave [the person] for 10 minutes, then try again. [Person] sometimes responds better to staff out of uniform so ask for support from the manager or senior staff'. Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring.

Where incidents or accidents had occurred, there was a clear record, which enabled the manager to identify any actions necessary to help reduce the risk of further incidents. Action had been taken in a timely manner to mitigate risks and this was clearly documented. In December 2016 an audit of the incident and accident record showed that there had been a slight increase of the number of falls in the home. As well as immediate action the providers and manager organised a visit from a foot care specialist, who provided support and advice to people about wearing appropriate shoes to prevent falling. Since this visit no one in the home has had a fall.

The provider and staff actively managed and reduced environmental risks. Processes were in place to ensure there was an appropriate standard of cleanliness and hygiene within the home to protect people, staff and visitors from the risk of infection. At the time of the inspection the home was undergoing refurbishment which had resulted in an increase in environmental risks. These risks were managed proactively through on going 'spot checks' throughout the day, people being accompanied while moving around the home and advise and support from health and safety professionals.

People told us and indicated they felt safe. One person said, "Oh yes, I feel very safe". Another person told us, "Staff look after me". Family members told us they did not have any concerns regarding their relative's safety. One family member said, "My [loved one] is very safe", and a second said, "I have no concerns at all about [my loved ones] safety".

Staff had the knowledge and confidence to identify safeguarding concerns and acted to keep people safe. All staff received training in safeguarding which helped them identify, report and prevent abuse. Staff told us about how they would safeguard people and actions they would take if they thought someone was experiencing abuse. One staff member said, "I would report concerns to the head of care or manager, I know they will investigate and do the right thing". Another staff member told us, "I would contact the safeguarding

team or CQC and would whistle blow if I needed to". The manager understood their safeguarding responsibilities and had reported concerns to the appropriate authority in a timely manner when required.

People and their families told us there were sufficient staff to meet people's needs. Comments included, "There seems to be enough staff", "The staff are always there when [my loved one] needs them", and, "Staff have time, they don't appear to be rushed". The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff responded to people's needs promptly. Staff we spoke to confirmed there were enough staff to provide appropriate care without being rushed in their duties.

The manager told us that staffing levels were based on the needs of the people using the service and said, "The staff are very good in reporting any concerns or issues they have about staffing levels so adjustments can be made". The manager told us that they often worked alongside the staff to provide support if needed and that this also allowed them to see any areas of particular pressure. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime and agency staff.

There was a robust recruitment process in place to help ensure that staff recruited were suitable to work with the people they supported. All potential new staff attended an interview which was completed by a member of the management team and a family member of a person living at the home. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

People received their medicines safely. A person said, "They [staff] give me my medicine". Medicines were administered by staff who had received appropriate training and had their competency to administer medicines safety assessed by a member of the management team. The manager also completed regular medicine 'spot checks' once a week and observed staff administering medicines three monthly to ensure their practice remained safe.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. On viewing the MAR chart no gaps were identified, this indicated that people received their medicines appropriately.

Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines.

There were suitable systems in place to ensure prescribed topical creams and ointments were applied correctly. This included body charts to identify where specific creams should be applied and records completed by care staff to confirm application. Topical creams had an 'opened on' date to help ensure these were not used after the safe time limit.

Staff respected people's rights to refuse prescribed medicines. There was a procedure in place for the covert administration of medicines. This is when essential medicines are placed in small amounts of food or drink and given to people. We saw all the correct documentation had been completed correctly, in line with the current legislation that protects people's rights.

During the medicine administration round staff were heard asking people how they would like to take their medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought people's consent. Staff remained with people until they were sure all medicines had been taken.

There were plans in place to deal with foreseeable emergencies. Fire safety equipment was maintained and checked regularly and people had personal evacuation plans in place. These included details of the support people would need if they had to be evacuated. Staff were aware of the action to take in the event of a fire and had been trained in the use of evacuation equipment.

Good

Is the service effective?

Our findings

People and their families told us they felt the service was effective and that staff understood people's needs and had the skills to meet them. One person said, "The staff are all good". A health professional told us the staff were knowledgeable about the people they supported and they did not have any concerns about the staff's ability to look after people effectively.

The provider had arrangements in place to ensure staff received an effective induction to enable them meet the needs of the people they were supporting. Staff told us that when they started working at Buttercup House Care Home they received a period of induction and worked alongside experienced staff before they were permitted to work unsupervised. New staff received mandatory training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

Staff had the skills and knowledge to carry out their roles and responsibilities effectively. Family members were confident in the abilities of the staff. A family member said, "The staff are very experienced people, they know what they are doing". Another family member told us, "They [staff] all seem very competent". The provider had a system to record the training that staff had completed and to identify when training needed to be updated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training which focused on the specific needs of people using the service, such as, dementia awareness and skin integrity. Staff understood the training they had received and how to apply it. For example, they explained how they would support a person to mobilise, how to use moving and handling equipment appropriately and how they provided care to people living with dementia. A health professional said, "Staff appear well trained and know what they are doing". Staff comments included, "I get lots of training, its varied; face to face, classroom, workbooks or on the computer" and "We are always doing training".

All staff received one-to-one sessions of supervision every three months. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal, with the manager or provider, to assess their performance and identify development needs. Staff told us these sessions were helpful and spoke positively about the support they received from management on a day to day basis. One staff member told us, "I can approach the manager at any time; they always listen and act if I need them to".

Staff obtained verbal consent from the people before providing them with care and treatment, such as offering to help them mobilise or to have an assisted wash. A staff member told us, "I will always get people's consent before I do anything". Another staff member said, "Some of the people are unable to give verbal consent to care; I will still always ask them and try and pick up clues from their facial expressions and body language to make sure they don't mind".

Staff assessed people's abilities to make decisions in line with the Mental Capacity Act (MCA) 2005. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. For example, where alert mats were in place to keep people safe and when medication was needed to be given covertly.

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 procedures for this in care homes 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. We found the provider was following the necessary requirements and DoLS applications had been made to the supervisory body where relevant. The manager carried out a review of the applications to ensure they were still required. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and the least restrictive option.

People were supported to have enough to eat and drink. Fluids and snacks were offered throughout the day and evening. People told us they enjoyed their meals. When we asked one person if they were enjoying their lunch they responded with, "It's alright yes, she [cook] is very good". Another person told us, "The food is very nice". Staff were aware of people's needs and offered support when appropriate. For example, one person needed full assistance with their meal and they were supported in a caring and unhurried way. The care staff member sat with them and spoke to them kindly about general and personal things that were important to the person; this demonstrated that they know about the person and their life well. The care staff member checked with the person that they were comfortable and asked if they had enough [to eat]. People were supported to eat independently and where necessary specialist cups, crockery and cutlery were provided. People were provided with a choice of food and an alternative was offered if they did not want what was offered.

People were supported to make informed decisions about meal and food choices through the use of verbal descriptions and photos. On the day of the inspection one person was unable to make a decision about the meal they would prefer and asked the cook to make this decision on their behalf. The cook said to the person, "How about sausages, you liked them last time". The person happily agreed to this meal choice.

Where nutritional risks were identified people were closely monitored to ensure their nutritional needs were met. Where issues and concerns were highlighted appropriate action had been taken by staff. This action included requesting guidance from health professionals and making changes to the menu. The kitchen staff were aware of people's likes and dislikes, allergies and preferences. Meals were appropriately spaced and flexible to meet people's needs.

People were supported to access appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. Staff knew people's health needs well and were able to describe how they met these needs. During the inspection we heard staff talk about a change in a person's mood and actions they were going to take, which included close monitoring and contact with healthcare professionals. A visiting health professional told us, "This is certainly one of the

homes I am not worried about". They continued with, "They call us appropriately, are proactive and will respond to any advice with give them.

At the time of the inspection the home was undergoing extensive refurbishment. The refurbishment plans included creating a suitable environment for people with a cognitive impairment to live. It was being decorated taking into account research to support people living with dementia or poor vision to find their way around. This included having bold signs on doors and key doors such as toilets and bathrooms being painted a bright colour so that they stood out. The people living at the home were being given the opportunity to choose the colour of the doors to their rooms to allow them to recognise this more easily. Throughout the building there were various homely items designed to assist with memories or provide interest and activity for people living with dementia.

Good

Is the service caring?

Our findings

People and their families were positive about the caring attitude of the staff, who they described as, "kind", and, "caring". A person told us, "The staff are always nice" and a family member said, "The staff are definitely caring, they speak really nicely to [my loved one]". We saw an email that had been sent to the provider by a relative, this said, 'Once again I am impressed with the care and attention provided at Buttercup House and feel immensely grateful that [my loved one] is with you'. Comments made by people and their families in the provider's quality assurance survey completed in December 2016 included, 'Everything is 10 out of 10' and 'I am very happy with everything, it's a very happy home'. A health care professional said, "It's a very calm home, the staff interact very well with the residents and are very gentle".

Staff members demonstrated that they cared about people and respected them as individuals. Their comments included, "The people living here still have feelings, they haven't lost these just because they have dementia", "I look after them how I would look after my nan and grandad", and, "I really want the people to be comfortable and happy, and have their wishes granted".

People were cared for with dignity and respect. Staff were heard speaking to people in a kind and caring way, with interactions between people and staff positive and friendly. We saw staff kneeling down to people's eye level to communicate with them. We heard good-natured banter between people and staff, showing they knew people well. Staff were attentive to people and checked whether they required any support. For example, one person became slightly restless and this was quickly noticed by a staff member. The staff member approached the person who then said, "I think I need to use the bathroom, will that be alright". The staff member responded with, "Of course, shall I help you to stand?" Another person was walking with a frame and a staff member walked with them gently and respectfully provided them with encouragement and reassurance, saying, "I'm with you" and "I'm right here".

Staff understood the importance of respecting people's choice. They spoke with us about how they cared for people and offered them choices in what they preferred to eat and where they wanted to spend their time. Staffs' understanding of respecting people's choice was further demonstrated when we overheard a conversation between a staff member and person about the lift that was being installed at the home. The person told the staff member that they would want to continue to use the stair lift when the lift was fitted. The person said, "I don't like lifts, it's silly really". The staff member responded by saying, "No its not [silly], we all have things we don't like. It's about what you feel happier with; you can still use the stair lift if that's what you would prefer".

Choices were offered in line with people's care plans and preferred communication style. Throughout people's care files there were comments about providing choices to people in relation to their care. Comments included, 'Please give [person] a choice of what they would like to wear', '[Person] usually likes to have a bath when their health allows, although showering has become their preferred method lately due to a decline in health' and 'Offer [person] bath or shower daily'.

People's privacy was respected when they were supported with personal care. Staff were able to describe

the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered. We observed staff knocking on doors, and asking people's permission before entering their bedrooms. People and their families confirmed this and commented, "I think [my loved ones] privacy is respected", and, "The door is always closed when I am getting help".

People were encouraged to be as independent as possible. A person told us, "Yes they [staff] will help me if I need them". A family member said, "They will always encourage [my loved one] to do things for themselves". Comments in care plans highlighted to staff what people could do for themselves and when support may be needed. For example one care plan stated, '[Person] wears dentures and requires assistance with removing and cleaning these'. Another care plan stated, 'Ensure the person has the correct footwear and frame to help them to mobilise safety and independently'. Staff understood the importance of maintaining people's independence and a staff member said, "We will encourage people to be independent, we don't want to take people's abilities away". Where appropriate, adjustments had been made to the environment to support people to remain independent.

People were supported to maintain friendships and important relationships. Care records included details of their circle of support and identified people who are important to the person. All of the families we spoke with confirmed that the manager and staff supported their loved ones to maintain their relationships. Families commented, "We [family] are made very welcome", "We can visit at any time", and, "I am kept updated with things going on in the home and often invited".

When people moved to the home, they or their family if appropriate were involved in assessing, planning and agreeing the care and support they received. The manager told us that when a person moved to the home they are encouraged to make their bedrooms their own by bringing in personal items that are familiar to them.

Good

Is the service responsive?

Our findings

People and their families told us they felt the staff were responsive to their needs. A family member said, "I am confident that [my loved one] gets the care they need". Another family member told us, "The staff will always get a doctor or nurse in to visit if [my loved one] was unwell". A third family member said, "They [staff] really understand [my loved ones] needs". This family member also gave us an example of how staff responded when their loved one had a reduced appetite. They said, "Staff do everything to encourage them to eat; they ate lunch with them and set up the table really nicely with a vase of flowers and table cloth". A health care professional told us, "[The manager] is really on the ball; they will call us [healthcare professionals] appropriately. The staff will always respond to the advice we give. The care provided is not regimented and is really person centred".

Although the home was undergoing extensive refurbishment and building work during the inspection the atmosphere was calm and relaxed. Family members and healthcare professionals confirmed that the building work had not appeared to have had any detrimental effects on the people living at the home. Family members, staff and health care professionals felt that this was due to the level of input from the staff who provided distractions when required, continual updates on the development from the provider and manager, keeping people and their families involved in the development and not admitting any new residents.

Staff were responsive to people's communication styles and gave people information and choices in a way they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. People's care plans contained a 'communication care plan' which provided information about their communication style. For example, one person's communication care plan identified that a person's ability to effectively communicate varied from day to day and instructed staff to speak clearly and slowly to ensure the person understood, before moving away.

People's care plans provided information to enable staff to give appropriate care in a consistent way. They were individualised and detailed people's preferences, likes and dislikes and how they wished to be cared for. People received personalised care from staff that supported them to make choices. Comments in care files included, '[Person] likes to get up between 08.00 and 08.30', '[Person] is able to tell you if they are in pain and where the pain is' and '[Person] doesn't like green vegetables'. These care files also included specific individual information to ensure medical needs were responded to in a timely way. One healthcare professional told us, "The staff seems to know the resident's well".

We saw people being supported by the staff as described in their care plans to maximise their independence. Records of daily care confirmed people had received care in a personalised way in accordance with their care plans, individual needs and wishes. Information provided in daily records was well detailed and informative which provided staff with clear and up to date information about people's needs and emotional wellbeing throughout the day. Staff were able to describe the care provided to

individual people and were aware of what was important to the person in the way they were cared for.

Staff were kept up to date about people's needs through handover meetings which were held at the start of every shift. These meetings provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. Relevant individual information was provided to staff during this meeting which included information about; a person who had chosen to do their personal care that morning unsupported, a change in a person's mood and how best to support them and input someone had received from a healthcare professional. During this handover meeting staff shared ideas and knowledge of how best to provide support to individual people.

Care and support was planned proactively and in partnership with the people, their families and healthcare professionals where appropriate. The manager completed assessments of the people before they moved to the home to ensure their needs could be appropriately met. The management team reviewed care plans monthly or more frequently if people's needs changed. Families told us that they were fully involved in the development and reviews of care plans. A family member said, "We are fully involved in [my loved ones] care and kept informed, both face to face, phone contact and emails".

People were provided with appropriate mental and physical stimulation through a range of varied activities. The service employed an activities co-ordinator and care staff told us that they often had time to sit and interact with the people living at the home. Activities were provided both in groups and individually and were adapted according to the likes and preferences of people on a day to day basis. People and their families were kept informed of up and coming events and daily activities though an activities timetable, emails, the monthly newsletter and directly from the staff. Activities included reminiscence, games, music, armchair exercises, word games, quizzes, films and arts and crafts. During the inspection we saw people being encouraged to interact with others and staff sitting and engaging with them. A family member told us, "There is enough for people to do, there are always things going on". Another family member said, "There is always plenty to do". A third family member told us about a time they visited and found people dancing and laughing.

People were supported to access the community when they wished and the manager told us that at times some people would be supported to walk to the local shop to get personal items. The manager and activities coordinator was in the process of arranging more group outing for people to places of their choosing and to local community groups. Staff were responsive to people's religious beliefs and they were supported and encouraged to maintain these if they wished.

The manager sought feedback from people's families on an informal basis when they met with them at the home, during telephone contact, email correspondence and during resident and relative meetings. Both people and their families felt able to approach the manager and provider at any time. Their comments included, "The manager and owners are really approachable", "I know that if I had any issues or concerns they would act", and, "I am always kept up to date about what is going on".

Residents and relative meetings were held four to six weekly to discuss all aspects of care and update people on the current refurbishment. During these meetings people and their families were given the opportunity to talk about any concerns or issues they had and to share ideas about the development of the service. Past meeting minutes were viewed which demonstrated that actions had been taken where required and people and their families had been fully involved in developing the service.

The manager and provider also sought formal feedback through the use of quality assurance survey questionnaires sent six monthly to people, their families, professionals and staff. We looked at the feedback

from the latest survey completed in December 2016. All responses to this survey were positive.

People and their families told us that they would feel comfortable raising concerns with the staff if they had any and were confident that any issues or concerns raised would be acted on. The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The manager told us they had received one complaint from a family member during the previous year. They explained the action they had taken to investigate the complaint and respond to the concern raised.

Good

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led. Family members also said they would recommend the home to their families and friends. One family member said, "The home is brilliantly managed and the owners are very involved". They went on to say, "They couldn't do anything more". Another family member described the manager and senior staff as, "Excellent". A health professional told us, "The manager is proactive and involved; they don't just sit in the office".

There was not a registered manager in place for the service; however the manager had commenced the process to register with the Commission. 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. Although there was no registered manager in place there was still a clear management structure. This structure consisted of the provider, director, manager, senior care staff and care staff. Staff understood the role each person played within this structure.

Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the service and care provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. A staff member said, "I can approach the manager or owners at any time, they will always listen and I know they will act". Another staff member told us, "I have a good relationship with the manager; they listen to me and will tell me off if they need to". Staff commented on the improvement of the service over the last six months. Their comments included, "There has been some really good changes in the last few months, the paperwork and the motivation of the staff has really improved" and "We are making really good progress, we aim to give the best care to the people living here, we will get there".

The provider was fully engaged in running the service and they told us their vision and values were built around, "Delivering high quality person centred care, in a safe, homely and calm atmosphere that is suitable for people living with a cognitive impairment". Staff members understood the values of the service and many described Buttercup House as, "Their [people's] home", and, "A home from home". People and their families echoed this and one said, "It [Buttercup House] is really family orientated". A family member described the providers involvement as, "Wonderful" and told us that when the provider visited the home "They would spend time with the people and will often sit for about an hour with [my loved one] just chatting". A member of staff said, "I have never worked in a home where the providers are as engaged as they are at Buttercup, it's really nice. They really care about the people, what they need and put them first".

The provider was responsive to new ideas and had developed links with external organisations and professionals to enhance the staff's and their own knowledge of best practice to drive forward improvements. The provider was a member of the Hampshire Care Association and interacted with other providers and professionals via the Southampton forum to understand and aid the development of high standards of care in the region. They also worked closely with a specialist training company to improve the

service provided to people with dementia.

The provider had suitable arrangements in place to support the manager, for example regular meetings, and these also formed part of the provider's quality assurance process. The manager confirmed that support was available to them from the provider.

Quality assurance systems were in place to monitor both the safety of the environment and the quality of the clinical care provided. Routine checks and audits were regularly carried out for a range of areas to enable the manager to monitor the operation of the service and to identify any issues requiring attention. The manager and provider carried out regular audits which included infection control, the cleanliness of the home, resident involvement and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. Weekly medicine audits were completed which covered all areas of medicines management. Other formal quality assurance systems were in place, including seeking the views of people, their relatives, staff and health professionals about the service they received via quality assurance questionnaires.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The provider and the manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area of the home.