Methodist Homes

Kenbrook

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

Overall summary

This inspection took place on 30 November 2015 and was unannounced. Kenbrook is a care home with nursing. The home is owned and operated by Methodist Homes Ltd. Kenbrook is registered to provide care and accommodation for up to 51 older people who may also be living with dementia.

At our last inspection on 5 February 2014 the service met the regulations inspected.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 spent time observing interaction between people and staff. On the day of our inspection we observed that people were well cared for and appropriately dressed.

Summary of findings

People who used the service said that they felt safe in the home and around staff. Relatives of people who used the service and care professionals we spoke with told us that they were confident that people were safe in the home.

Systems and processes were in place to help protect people from the risk of harm and staff demonstrated that they were aware of these. Staff had received training in safeguarding adults and knew how to recognise and report any concerns or allegations of abuse. Risk assessments had been carried out and staff were aware of potential risks to people and how to protect people from harm.

On the day of the inspection we observed that there were sufficient numbers of staff to meet people's individual care needs. Staff did not appear to be rushed and were able to complete their tasks. Staff we spoke with confirmed that there were sufficient numbers of staff to safely care for people. The registered manager explained that there was flexibility in respect of staffing and staffing levels were regularly reviewed depending on people's needs and occupancy levels.

Systems were in place to make sure people received their medicines safely. Arrangements were in place for the recording of medicines received into the home and for their storage, administration and disposal.

We found the premises were clean and tidy and there were no unpleasant odours. There was a record of essential inspections and maintenance carried out. The service had an Infection control policy and measures were in place for infection control.

Staff had been carefully recruited and provided with induction and training to enable them to care effectively for people. They had the necessary support, supervision and appraisals from management. Staff told us that they worked as a team and communication was good.

People's health and social care needs had been appropriately assessed. Care plans were person-centred, detailed and specific to each person and their needs. Care preferences were documented and staff we spoke with were aware of people's likes and dislikes. Identified risks associated with people's care had been assessed and plans were in place to minimise the potential risks to people. People told us that they received care, support and treatment when they required it. Care plans were reviewed monthly and were updated when people's needs changed.

Staff we spoke with had an understanding of the principles of the Mental Capacity Act (MCA 2005). Capacity to make specific decisions was recorded in people's care plans.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS ensure that an individual being deprived of their liberty is monitored and the reasons why they are being restricted is regularly reviewed to make sure it is still in the person's best interests. The home had made some necessary applications for DoLS and we saw evidence that authorisations had been granted. We noted that the home had eleven further applications to make and spoke with the registered manager about this. The registered manager confirmed that these applications would be made.

There were suitable arrangements for the provision of food to ensure that people's dietary needs were met. People were mostly satisfied with the meals provided. Food looked appetising and was freshly prepared and presented well. Details of special diets people required either as a result of a clinical need or a cultural preference were clearly documented.

People and relatives spoke positively about the atmosphere in the home. Bedrooms had been personalised with people's belongings to assist people to feel at home.

Relatives told us that there were sufficient activities available. We looked at the activities timetable and saw activities such as exercise groups, religious services, flower arranging, and music therapy. The activities coordinator explained that there was a therapeutic programme for people who were bedridden. On the day of the inspection we saw that people got involved with Christmas tree decorating.

Staff were informed of changes occurring within the home through staff meetings and we saw that these

Summary of findings

meetings occurred monthly and were documented. Staff told us that they received up to date information and had an opportunity to share good practice and any concerns they had at these meetings.

The home had carried out an annual satisfaction survey in October 2015 and were awaiting the results from the survey. We noted that the results from the last survey were positive.

There was a management structure in place with a team of nurses, care staff, kitchen and domestic staff, deputy manager and the registered manager. Staff told us that the morale within the home was good and that staff worked well with one another. Staff spoke positively about working at the home. They told us management was approachable and the service had an open and transparent culture. They said that they did not hesitate about bringing any concerns to the registered manager.

There was a comprehensive quality assurance policy which provided detailed information on the systems in place for the provider to obtain feedback about the care provided at the home. The service undertook a range of checks and audits of the quality of the service and took action to improve the service as a result. Relatives spoke positively about management in the home and staff. They said that the registered manager was approachable and willing to listen.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People who used the service, relatives and care professionals we spoke with said that they were confident the home was safe.

Staff were aware of different types of abuse and what steps they would take to protect people. Risks to people were identified and managed so that people were safe and their freedom supported and protected.

Staffing arrangements were adequate and staff confirmed that there were sufficient numbers of staff to care for people safely.

We saw that appropriate arrangements were in place in relation to the management and administration of medicines.

Is the service effective?

Good

The service was effective. Staff had completed training to enable them to care for people effectively. Staff were supervised and felt well supported by their peers and the registered manager.

People were provided with choices of food and drink. People's nutrition was monitored and dietary needs were accounted for.

People were able to make their own choices and decisions. Staff and the registered manager were aware of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and the implications for people living in the home.

People had access to healthcare professionals to make sure they received appropriate care and treatment.

Is the service caring?

Good

The service was caring. We saw that people were treated with kindness and compassion when we observed staff interacting with people who used service. The atmosphere in the home was calm and relaxed.

Wherever possible, people were involved in making decisions about their care. Care plans provided details about people's needs and preferences. Staff had a good understanding of people's care and support needs.

People were treated with respect and dignity. Staff respected people's privacy and dignity and were able to give examples of how they achieved this.

Is the service responsive?

Good

The service was responsive. Care plans were person-centred, detailed and specific to each person's individual needs. People's care preferences were noted in the care plans.

There were activities available to people and a timetable was in place. People and relatives spoke positively about the activities available.

Summary of findings

A formal satisfaction survey had been carried out in October 2015. The home was awaiting feedback from this.

The home had a complaints policy in place and there were procedures for receiving, handling and responding to comments and complaints. Complaints had been appropriately responded to.

Is the service well-led?

Good

The service was well led. People, relatives and care professionals told us that the registered manager was approachable and they were satisfied with the management of the home.

The home had a clear management structure in place with a team of care staff, kitchen and domestic staff, deputy manager and the registered manager.

Staff were supported by the registered manager and told us they felt able to have open and transparent discussions with her.

The quality of the service was monitored. Regular audits and observations were carried regularly. There were systems in place to make necessary improvements.

Kenbrook

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, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced inspection on 30 November 2015. The inspection team consisted of one inspector, a pharmacist specialist advisor, a nurse specialist advisor 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.

Before we visited the home we checked the information that we held about the service and the service provider including notifications about significant incidents affecting the safety and wellbeing of people who used the service.

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing.

We reviewed fourteen care plans, eight staff files, training records and records relating to the management of the service such as audits, policies and procedures. We spoke with ten people who used the service and eleven relatives. We also spoke with the registered manager, deputy manager and nine staff. We spoke with two care professionals who had regular contact with the home.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe in the home, they told us "yes" or nodded to indicate that they did. Relatives told us that they were confident that people were safe in the home and around care staff. One relative said, "Safe. Absolutely. My [relative] has a connection here. He feels safe here." Another relative told us, "It is definitely safe here." Another relative said, "[My relative's] safe here and I haven't seen any pressure applied to her or poor handling." Care professionals we spoke with told us that they were confident that people were safe in the home and did not raise any concerns in respect of this.

People's care needs had been carefully assessed. Care plans we reviewed included relevant risk assessments, such as the Malnutrition Universal Screening Tool (MUST) risk assessment, used to assess people with a history of weight loss or poor appetite. Pressure ulcer risk assessments included the use of the Waterlow scoring tool and falls risk assessment. People at risk of falls had fall diary sheets which included 24 hour observation charts, incident and accident forms which were completed following a fall. It was evident that the service had identified individual risks to people and put actions in place to reduce the risks. These included preventative actions that needed to be taken to minimise risks as well as measures for staff on how to support people safely. Risk assessments were reviewed monthly and were updated when there was a change in a person's condition and this was confirmed by staff we spoke with.

As part of the inspection we looked at how skin integrity of people who used the service was managed. We saw evidence that those people who had been assessed to be at high risk of developing pressure ulcers based on their Waterlow risk assessment, had measures in place to prevent them from developing pressure ulcers. People who were at very high risk were provided with alternating pressure relieving air mattresses with good functioning profiling beds. There were accurate records of repositioning charts during the day and during the night. These charts were kept and maintained for people at very high risk of developing pressure ulcers. We found that air mattresses were set correctly and according to people's weight.

We spoke with staff about their knowledge on the management and prevention of pressure ulcers as well as how to set the air mattresses. Staff demonstrated good knowledge on how to set and monitor the effectiveness of the air mattresses. Staff also had a good understanding of wound management and prevention.

Safeguarding policies and procedures were in place to help protect people and minimise the risks of abuse to people and the local safeguarding team contact details were displayed in the home. Staff had received training in safeguarding people. They were able to describe the process for identifying and reporting concerns and were able to give example of types of abuse that may occur. They told us that if they saw something of concern they would report it to the registered manager or deputy manager. Staff were also aware that they could report their concerns to the local safeguarding authority, police and the CQC. The service had a whistleblowing policy and contact numbers to report issues were available. Staff were familiar with the whistleblowing procedure and were confident about raising concerns about any poor practices witnessed.

We looked at the staff records and discussed staffing levels with the registered manager. On the day of inspection there was a total of 50 people who used the service. The staffing level consisted of two nurses and ten care staff on duty during the day. The registered manager and deputy manager were supernumerary. In addition the home had kitchen and other household staff. On the day of the inspection the atmosphere was calm in the home and staff were not rushed. Through our observations and discussions with people, their relatives, staff and management we found there were enough staff to meet the needs of the people living in the home. The registered manager told us there was consistency in terms of staff so that people who used the service were familiar with staff. This was evident through our observations. We saw that people who used the service were comfortable around staff. We noted that there was a low staff turnover rate with the majority of staff having worked at the home for a considerable amount of time. The home also had bank staff that they used when they required and the registered manager confirmed that they did not use agency staff. The registered manager told us there was flexibility in staffing levels so that they could deploy staff where they were needed. For example, if people needed to be supported on day trips or when people had to attend appointments. The registered manager told us staffing levels were assessed depending on people's needs and occupancy levels.

Good

Is the service safe?

We looked at the recruitment process to see if the required checks had been carried out before staff started working at home. We looked at the recruitment records for eight members of staff and found comprehensive background checks for safer recruitment including enhanced criminal record checks had been undertaken and proof of their identity and right to work in the United Kingdom had also been obtained. Two written references had been obtained for staff. The registered manager confirmed that they did not employ any staff until all the necessary checks had been carried out and that they had a comprehensive system in place and we saw evidence of this.

The home had plans in place for a foreseeable emergency. This provided staff with details of the action to take if the delivery of care was affected or people were put at risk. For example, in the event of a fire. The fire plan was on display throughout the home clearly indicating fire exits and escape routes. We also observed that each person had a personal emergency evacuation plan (PEEP) in place. Risks associated with the premises were assessed and relevant equipment and checks on gas and electrical installations were documented and up-to-date.

Systems were in place to make sure people received their medicines safely. The home had a medicines policy and operational procedures which were dated May 2015 and these covered all aspects of the safe handling of medicines including the handling of medicines errors. All registered nurses had their competency to administer medicines assessed annually and care staff were assessed on how to apply creams and other topical products. Staff who administered medicines told us they had completed training and understood the procedures for safe storage, administration and handling of medicines.

We looked at a sample of 27 medicines administration records (MAR) during the inspection. We saw that there was a record of people's currently prescribed medicines and we observed no omissions in the recording of allergy status, receipts, administration or disposal of medicines on the MAR we looked at. The home carried out daily stock checks of all medicines and we looked at a sample of 28 and saw just one discrepancy of one tablet. This accurate record keeping assured us that people were receiving their medicines as prescribed.

Variable doses of medicines such as one or two were recorded accurately so that the prescriber could assess the efficacy of the dose. Several people were prescribed the anticoagulant warfarin and there was evidence of regular blood tests and printed results of the latest prescribed dose. Other people prescribed high risk medicines such as methotrexate and phenytoin also had their blood monitored for potential side effects to their medicines.

When a person was prescribed a medicine as required for mood or as a laxative or for pain there was a protocol in place so that all staff knew when the person needed their medicine and how often they could give them. We observed that there was a care pathway in place for these people so that nursing staff knew when they should contact the palliative care team to initiate treatment.

For people prescribed medicines for their diabetes we observed diabetic monitoring charts and detailed care plans. The home's policy was for two people to administer and witness the administration of insulin and we always saw two signatures in place. When someone was prescribed an anticonvulsant (drugs that prevent or reduce the severity and frequency of seizures in various types of epilepsy) there was a protocol in place to manage their seizures and we saw that a seizure chart was completed to record such events.

We looked at the storage of medicines in the home and noted that all were secure. Fridge temperatures were within the required range and controlled drugs were secure and all stock balances correct.

We looked at the home's audits and in addition to the stock checks we saw that there were both monthly and three monthly audits. We saw that the home documented the action taken when concerns were identified. Communication books were used by nursing staff to hand over at shift changes and also by visiting GP's.

The premises were well-maintained, clean and there were no unpleasant odours. There was an infection control policy and measures were in place for infection prevention and control. A cleaning schedule was in place which allocated cleaning responsibilities to staff to ensure that the home was kept clean and regularly monitored. Staff we spoke with had access to protective clothing including disposable gloves and aprons. We observed that soiled pads and linen were disposed appropriately, soiled linen in a red bag and pads in a yellow bag.

Good

Is the service effective?

Our findings

People who used the service and relatives indicated that they were satisfied with the care provided at the home. One relative told us, "I can't fault [my relative's] care and, of the two or three other homes I've seen, none were as friendly and felt so much a family place." Another relative said, "I can't praise the staff enough. They are always there when you need them. Staff always make best efforts." One care professional told us, "It is one of the best homes."

People had their healthcare needs closely monitored. Care records of people were well maintained and contained important information regarding medical conditions, behaviour and any allergies people may have. There was evidence of recent appointments with healthcare professionals such as people's dentist, optician and GP. Information following visits by GP and other professionals were documented in people's records. One care professional we spoke with informed us that they observed that people were well cared for and staff maintained good liaison with them regarding the health of people. This professional expressed no concerns regarding the welfare of people.

People who used the service and relatives told us that the food was good. One relative said, "I eat lunch – it is edible and there is a good selection". Another relative said, "The food is very good on the whole." Another relative said, "The food is well presented and there is a good balance."

The home had a three weekly menu and it included a variety of different types of foods. There were alternatives for people to choose from if they did not want to eat what was on the menu. During the inspection we observed people having their breakfast and lunch, which was unhurried. We observed that people ate their breakfast at different times depending on when they wished to eat. The atmosphere during lunch was relaxed. Dining tables were laid attractively and people sat at tables with one another and were able to engage with staff and people who use the service. We observed that lunch was presented attractively.

We noted some examples of good practice. We saw staff turning off the television and leaving music playing during lunch. This helped people using the dining area to focus on the meal. We saw the staff took care to offer people choices about what they wanted. People were offered water, juice and teas and coffees during the meal. Staff were attentive and created a pleasant atmosphere chatting to people over lunch. We saw that people who were supported to eat were helped in a respectful manner with staff sitting next to them, and taking the time required to help them to eat. We saw one person become upset and distressed about the table she was sat at during lunch. One member of staff observed this and helped the person move to another table which relaxed them and it was evident that they were happy. This was a further example of good practice. We saw that people were able to eat in their own rooms if they preferred and there seemed to be enough staff available to support people in their rooms as required.

The kitchen was clean and we noted that there were sufficient quantities of food available. We checked a sample of food stored in the kitchen and found that food was stored safely and was still within the expiry date. Food in packaging that had been opened was appropriately labelled with the date it was opened so that staff were able to ensure food was suitable for consumption.

Care records showed that nutritional needs of the people who used the service were met. From the care plans viewed, there were no people with significant weight loss. Some people did have low weight and a low body mass index, however the service had referred them to the dietician or GP for advice. People's weights were recorded monthly so that the service was able to monitor people's nutrition. We saw recorded evidence in the fluid and food charts that people were being fed during meal times. Evidence from the care records showed that one person was overweight and staff had identified this and put the person on a weight management plan. This indicated that staff had the ability to manage people who were overweight.

Staffs had the necessary equipment to manage people's needs. For instance, there were hoists available and they were in good working order. There were slings for different sizes used for people. We noted that people did not have individual slings and people who were assessed to require hoisting should have their individual hoist. We spoke with the registered manager about this and she confirmed that she was aware of this and showed us evidence that the service had ordered the necessary slings.

People receiving end of life care had the appropriate plans in place. They also had "Do not attempt cardiopulmonary

Good

Is the service effective?

resuscitation" (DNACPR) in place. All the DNACPR's we viewed were signed by the GP, relatives and nursing staff and were up to date. There were also care plans in place which clearly stated the end of life wishes for people.

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. 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.

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 noted that care plans contained information about people's mental state and cognition. The registered manager explained that the service had introduced a new "Mental Capacity assessment and best interest plan" document. We saw evidence of this and noted that the form was comprehensive. The registered manager explained that they were in the process of completing these for all people. Staff had knowledge of the MCA and training records confirmed that they had received training in this area. Staff were aware that when a person lacked the capacity to make a specific decision, people's families, staff and others including health and social care professionals would be involved in making a decision in the person's best interests.

We also found that, where people were unable to leave the home because they would not be safe leaving on their own, the home had made some applications for the relevant authorisations called Deprivation of Liberty Safeguards (DoLS). We noted that the service had made some necessary applications and the authorisations were in place. The registered manager confirmed that the remaining eleven applications would be made shortly.

Staff had the knowledge and skills to enable them to support people effectively. We saw evidence that staff had undertaken a comprehensive induction when they started working at the service. There was on-going training to ensure that staff had the skills and knowledge to effectively meet people's needs. Training records showed that staff had completed training in areas that helped them to meet people's needs. Topics included safeguarding, medicines, first aid, fire training, infection control and food safety. Staff spoke positively about the training they had received and were able to explain what they had covered during the training sessions. The registered manager also explained that after training sessions, staff were required to complete an assessment to ensure that they were aware of the key points.

There was evidence that staff had received regular supervision sessions and this was confirmed by staff we spoke with. Supervision sessions enabled staff to discuss their personal development objectives and goals. We also saw evidence that staff had received an annual appraisal about their individual performance and had an opportunity to review their personal development and progress.

Staff told us that they felt supported by their colleagues and management. They were positive about working at the home. They commented on the good team spirit amongst staff, good knowledge and skills possessed by all staff in the home which had helped to maintained a good working standard in the home.

Good

Is the service caring?

Our findings

People told us that they were well cared for in the home and that they were treated with respect. One person said, "They knock on my door and I have immense admiration for them." Another person told us, "Four other homes I looked at had no atmosphere and were prissy or like a prison, but here it has the right atmosphere."

Relatives told us that they were confident that people were well cared for in the home. They said that they had seen a good working relationship between staff and people. Another relative told us, "The staff are friendly and human, they are not cold and distant, and they have a personal relationship with the residents." Another relative said, "[My relative] is always clean and well-dressed and her nails have been manicured." Another relative told us, "[My relative] seems happy, is treated with respect, and the staff know how to handle her moods."

Care professionals told us that they were confident that people were well cared for in the home and said that they had no concerns regarding this. One care professional said, "Excellent care in the home. There is a homely feel. Staff are so helpful."

We observed respectful and caring interactions between care staff and people who used the service. Care staff showed interest in people and were constantly present to ensure that people were alright and their needs attended to. Staff were attentive and talked in a gentle and pleasant manner to people. Care staff smiled and asked people how they were. People responded by either smiling or nodding. During the inspection, we observed one person become agitated and distressed when walking from the lounge to the dining room. A staff member noticed this and went to speak with the person and provided them with reassurance. This member of staff was patient and encouraged the person to walk independently to the dining room. The person responded well to the staff member's intervention. People appeared to feel comfortable and at ease in the presence of staff.

Staff we spoke with had a good understanding of the importance of treating people as individuals and respecting their dignity. They also understood what privacy and dignity meant in relation to supporting people with personal care. We saw that the home had a comprehensive policy on privacy and dignity which focused on valuing the individuality of each person and communicating with people in ways which were meaningful to them. Dignity and respect were included in the induction programme for new staff. We saw staff knocked on people's bedroom doors and waited for the person to respond before entering. Bedroom and bathroom doors were closed when staff supported people with their personal care needs.

We saw some detailed information in people's care plans about their life history and their interests. Staff could provide us with information regarding people's background, interests and needs. This ensured that staff were able to understand and interact with people.

People were supported to maintain relationships with family and friends. Relatives told us that they were well treated whenever they visited the home and they were kept informed about their family member's progress.

Care plans included information that showed people had been consulted about their individual needs including their spiritual and cultural needs. The registered manager and relatives told us representatives of various faiths and denomination visited the home on a regular basis to support people with their spiritual needs. One relative told us, "[My relative] feels assured with Christian faith and there is a regular Chaplain service." Staff we spoke with had a good understanding of equality and diversity (E & D) and respecting people's individual beliefs, culture and background. The home had a policy on ensuring equality and valuing diversity and staff had received training in ensuring equality and valuing diversity. They informed us that they knew that all people should be treated with respect and dignity regardless of their background and personal circumstances. Records showed equality and diversity was included in the staff induction programme. Staff confirmed they had E&D training. Kitchen staff informed us that they were fully aware of people's cultural meal requests and we saw that this information had been documented. Vegetarian and halal meals were provided for some people who used the service.

People had the use of a quiet lounge as well as a reminiscence lounge and music room. The lounges were distinctively decorated. People had free movement around the home and could choose where to sit and spend their recreational time. We saw people were able to spend time the way they wanted. Some people chose to spend time in the communal lounges and some people chose to spend time in their bedroom.

Good

Is the service caring?

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. Care plans had been signed by people or their representatives to show that they had agreed to the care they received. Care plans were up to date and had been evaluated by staff and reviewed with people, their relatives and professionals involved. This provided staff with current guidance on meeting the needs of people. Staff we spoke explained to us that they respected the choices people made regarding their daily routine and activities they wanted to engage in.

All bedrooms were for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as photographs and ornaments, to assist people to feel at home.

Good

Is the service responsive?

Our findings

People who used the service and relatives informed us that they were satisfied with the care provided in the home. One relative told us, "As [my relative's] needs have changed, they have been flexible and able to meet his needs'" Another relative said, "Staff are always very good. They are caring and helpful. They are hospitable and welcoming. They think about the little things." One care professional told us, "Staff really do listen and follow advice."

The home provided care which was individualised and person-centred. People and their representatives were involved in planning care and support provided. People's needs had been carefully assessed before they moved into the home. These assessments included information about a range of needs including health, social, care, mobility, medical, religious and communication needs. Care plans were prepared with the involvement of people and their representatives and were personalised. Staff had been given guidance on how to meet people's needs and when asked they demonstrated a good understanding of the needs of each person. We noted that care plans included information about people's religious and cultural practice so that staff could support people appropriately.

Care plans were reviewed monthly by staff and were updated when people's needs changed. The registered manager explained that the regular reviews enabled staff to keep up to date with people's changing needs and ensured that such information was communicated with all staff.

People who used the service and relatives we spoke with told us there were activities available for them to participate in. They spoke positively about the activities co-ordinator and said they had a good rapport with her. One relative said, "I am impressed by the activities. They have a very good variety on offer. The musical activities are good."

We saw that there was an activities timetable. The home employed an activities co-ordinator who was on duty during the inspection. On the day of inspection we observed people taking part in Christmas tree decorating. Activities for the week, including weekends, were shown in an 'Activities and Events' booklet that had been distributed to residents and relatives. We looked at the activities timetable and saw activities such as exercise groups, religious services, flower arranging, and music therapy. The activities co-ordinator explained that there was a therapeutic programme for people who were bedridden. The home had a programme called, "Seize the day" which was an invitation to all people who used the service to fulfil an ambition or dream and we saw posters for this displayed throughout the home.

There was a system in place to obtain people's views about the care provided at the home. We saw evidence that resident's meetings were held so that people could raise any queries and issues. We noted that these meetings were documented. We also saw evidence that relative's meetings were held quarterly. On the day of the inspection we noted that a relative's meeting took place and we saw relatives attend this meeting. Relative's spoke openly during this meeting and were able to discuss any concerns they had as well as up and coming events.

There was a complaints policy which was displayed throughout the home. There were procedures for receiving, handling and responding to comments and complaints. We saw the policy also made reference to contacting the CQC and local authority if people felt their complaints had not been handled appropriately by the home. The service had a system for recording complaints and we observed that complaints had been dealt with appropriately in accordance with their policy.

Good

Is the service well-led?

Our findings

People and relatives expressed confidence in the management of the home. One relative said, "I've visited four homes and this one is organised better, and I wouldn't hesitate to recommend it to anyone." Another relative told us, "The manager is professional and knowledgeable." Another relative said, "The manager is very supportive and is knowledgeable of my [relative's] needs. They work with me and are very good with people."

There was a management structure in place with a team of nurses, care staff, kitchen and domestic staff, the deputy manager and the registered manager. Staff spoke positively about working at the home. All staff told us that the morale within the home was very good and that staff worked well with one another. They told us management was approachable and the service had an open and transparent culture. They said that they did not hesitate to bring queries and concerns to the registered manager or deputy manager. One member of staff told us, "The manager is a mother to all of us. She is very helpful. The team gets on well." Another member of staff said, "I feel supported by the manager. There is good communication in the home. Morale is good."

Care professionals we spoke with were positive about management in the home. One care professional said, "The manager is wonderful. I can talk to her freely. There is good communication."

Care documentation was well maintained, up to date and comprehensive. The home had a range of policies and procedures to ensure that staff were provided with appropriate guidance to meet the needs of people. These addressed topics such as infection control, safeguarding and health and safety. Staff were aware of these policies and procedures and followed them. People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential.

Staff were informed of changes occurring within the home through staff meetings and we saw evidence that these meetings occurred monthly and were documented. Staff told us that they received up to date information and had an opportunity to share good practice and any concerns they had at these meetings. Regular management meetings were held so that managers could discuss higher level issues and we saw that these were documented.

There was a comprehensive quality assurance policy which provided detailed information on the systems in place for the provider to obtain feedback about the care provided at the home. The service undertook a range of checks and audits of the quality of the service and took action to improve the service as a result. We saw evidence that regular audits and checks had been carried out by the registered manager and assistant managers in various areas such as care documentation, health and safety, safeguarding, medicines, complaints/compliments, staff files and training. We saw evidence that management carried out regular observations around the home and these were documented.

Accidents and incidents were recorded and analysed to prevent them reoccurring and to encourage staff and management to learn from these.