Park Lane Health Care (Moorgate) Limited

Moorgate Lodge

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This was an unannounced inspection carried out on 28 and 29 July 2015. We last inspected the service in July 2014 and found they were meeting the Regulations we looked at.

Moorgate Lodge is a care home providing care for 56 older people. The service is located on the outskirts of Rotherham. The service is divided into three units on three floors accessed by a lift. There is parking and people have access to secure gardens. There are several communal areas including lounges dining areas and a separate activity room. At the time of this inspection there were 53 people who used the service living at the home.

The service has a registered manager who has been registered with the Care Quality Commission since February 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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 told us they felt safe living in Moorgate Lodge. Everyone we spoke with told us they were confident that they could tell the staff whatever they needed to if they were worried about anything. There were procedures to follow if staff had any concerns about the safety of people they supported.

The requirements of the Mental Capacity Act 2005 were in place to protect people who may not have the capacity to make decisions for themselves. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment.

People's physical health was monitored as required. This included the monitoring of people's health conditions and symptoms so appropriate referrals to health professionals could be made. The clinical lead nurse told us how they had involved health professionals when managing one person who they were trying to manage behaviours that challenged others. The nurse also gave examples where multidisciplinary agencies were involved with one person's care and treatment.

There were sufficient staff with the right skills and competencies to meet the assessed needs of people living in the home. Staff were aware of people's nutritional needs and made sure they supported people to have a diet that met their nutritional needs. However, several people we spoke with told us they thought the standard of meals was not very good.

People were able to access activities. The activity coordinator had developed a weekly plan of activities. People could also access religious services which were held periodically at the home. One the first day of our inspection people were given a choice to attend a religious service held at one of the sister homes which is on the same site as Moorgate Lodge.

We found the home had a friendly relaxed atmosphere which felt homely. Staff approached people in a kind and caring way which encouraged people to express how and when they needed support. Everyone we spoke with told us that they felt that the staff knew them and their likes and dislikes. A person said, "They understand perfectly what my requirements are."

Staff told us they felt supported and they could raise any concerns with the registered manager and felt that they were listened to. People told us they were aware of the complaints procedure and said staff would assist them if they needed to use it. We found records that confirmed complaints were investigated and responded to in a timely manner.

There were effective systems in place to monitor and improve the quality of the service provided. We saw copies of reports produced by the registered manager and the provider. The reports included any actions required and these were checked each month to determine progress.

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.

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the home's procedures in place to safeguard adults from abuse.

People's health was monitored and reviewed as required. This included appropriate referrals to health professionals. Individual risks had been assessed and identified as part of the support and care planning process.

There were enough qualified, skilled and experienced staff to meet people's needs. We saw when people needed support or assistance from staff there was always a member of staff available to give this support.

Medicines were stored and administered safely. Staff had received the appropriate training to administer medication safely.

Is the service effective?

Requires Improvement

The service needed some improvements to make them more effective.

Each member of staff had a programme of training and were trained to care and support people who used the service safely and to a good standard.

The staff we spoke with during our inspection understood the importance of the Mental Capacity Act in protecting people and the importance of involving people in making decisions. We found the service had started to meet the requirements of the Deprivation of Liberty Safeguards.

People's nutritional needs were met. The food we saw, provided variety and choice and ensured people's nutritional needs were met. We observed people being given choices of what to eat and what time to eat. However people told us that the meals could be improved.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received. We saw staff had a warm rapport with the people they cared for. Relatives told us they were satisfied with the care at the home. They found the registered manager approachable and available to answer questions they may have had.

People had been involved in deciding how they wanted their care to be given and we found this was written in their plans of care.

Is the service responsive?

Good

The service was responsive.

Summary of findings

We found that peoples' needs were thoroughly assessed prior to them moving in to this service. Relatives told us they had been consulted about the care of their relative before they moved into the home, and at reviews.

People were encouraged to retain as much of their independence as possible and those we spoke to appreciate this. People could access some activities that were planned both in the home and in the community.

The service had a complaints procedure that was accessible to people who used the service and their relatives. People told us they were aware of the procedure and some people said if they were concerned about anything they would tell their relative.

Is the service well-led?

Good

The service was well led.

The registered manager listened to suggestions made by people who used the service and their relatives. Their views were regularly sought and people and their relatives could attend meetings to discuss any issues.

The systems that were in place for monitoring quality were effective. Where improvements were needed, these were addressed and followed up to ensure continuous improvement.

The service worked well to ensure people received prompt involvement with health professionals and there was a sense of belonging to the community.

Accidents and incidents were monitored monthly by the manager to ensure any triggers or trends were identified.

Moorgate Lodge

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 28 and 29 July 2015 and was unannounced on the first day. The inspection team consisted of two adult social care inspectors and an expert by experience with expertise in care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the information received about the service from notifications sent to the Care Quality Commission by the registered manager. This included regular updates from the provider who was happy to discuss any issues the home may have had. We also contacted the local authority commissioners who also monitor the service provided.

We spoke with the registered manager, the clinical lead nurse, two nurses, seven care staff, and the activity coordinator. We also spoke with 12 people who used the service and seven relatives. This helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

We spent time observing care throughout the service. We also 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 looked at documentation relating to people who used the service, staff and the management of the service including eight recruitment and training files for staff. We looked at seven people's written records, including the plans of their care. We also looked at the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they had improved in the way that they identified areas for improvement.

Good

Is the service safe?

Our findings

We asked people whether they felt safe in the home. Everyone we spoke with were clear that they did feel safe. This was also reflected in responses from visitors to the home when we asked about their relative. One person said, "These carers wouldn't let anything bad happen to me. They look after us all really well." People we spoke with could name a member of staff they would speak to if they had a concern about safety and felt this person would take their concern seriously and sort any problems they told them about.

A safeguarding adult's policy was available and staff were required to read it as part of their induction. We looked at information we hold on the provider and found there were no ongoing safeguarding investigations.

Staff we spoke with told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact to report any concerns or incidents of abuse. They told us they knew how to contact the local authority Adult Protection Unit and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the registered manager knowing that they would be taken seriously.

The registered manager told us that they had policies and procedures to manage risks. There were emergency plans in place to ensure people's safety in the event of a fire or other emergencies at the home. We saw there was an up to date fire risk assessment which had been agreed with the fire safety officer. People's risks were appropriately assessed, managed and reviewed. We looked at seven people's care records and saw that individual risk assessments had been undertaken with care and support planned to ensure their safety. For example, we saw one person had turn charts because they were cared for in bed. The charts confirmed that staff were following the persons care plan to reduce the risk of developing pressure sores.

Systems were in place to make sure that managers and staff learnt from events such as accidents and incidents, complaints and concerns. This reduced the risks to people and helped the service to continually improve. The clinical lead nurse told us that people were referred to the 'Care Home Liaison Team' if they became at risk from frequent falls. This demonstrated the service works closely with other health professionals where a particular risk was identified.

We found the home had robust recruitment and selection procedures to ensure suitable staff are employed to work at the home. The registered manager told us that staff were not allowed to commence employment until a Disclosure and Barring Service (DBS) check and references had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. We confirmed this when we looked in the staff records. All new staff completed a full induction programme, and they also shadowed more experienced staff before working with people on their own.

We looked at the number of staff that were on duty and checked the staff rosters to confirm the number were correct. The registered manager had used a dependency tool to ensure sufficient staff with the right skills and competencies were on duty to meet people's needs. We asked staff about the levels working during the day. One staff member said, "We are usually alright but if a member of staff phones in sick, like today, it makes it hard to attend to people's needs when they require our assistance." One person said, "They're short staffed today and you can see they [the care workers] are running around like mad trying to see to everybody." Another person said, "I can tell when they're short staffed because I have to wait longer for someone to answer my buzzer." We discussed these comments with the registered manager and clinical lead nurse. They said staffing levels were determined looking at the dependency of people and listening to the staff when they say they can't meet people's needs effectively. They said they constantly reviewed the levels and would take the comments made into consideration.

There were appropriate arrangements in place to ensure that people's medicines were safely managed, and our observations showed that these arrangements were being adhered to. Medication was securely stored. Drug refrigerator temperatures were checked and recorded to ensure that medicines were being stored at the required temperatures. We checked records of medication administration and saw that these were appropriately kept.

Good

Is the service safe?

There were systems in place for stock checking medication, and for keeping records of medication which had been destroyed or returned to the pharmacy. Again, these records were clear and up to date.

The medication administration record (MAR) sheets used by the home included a photo of the person and pictures of each medication that had been supplied to the home. This helped to make sure that the nursing staff knew safely which medication they were administering.

Medication was only handled by nursing staff who had received training in relation to medication. The nurse we spoke with confirmed that they had completed an in-depth on-line training course and also had a yearly competency check. We saw records that confirmed this.

There were up to date policies and procedures relating to the handling, storage, acquisition, disposal and administration of medicines. People's care records contained details of the medication they were prescribed, any side effects, and how they should be supported in relation to medication.

Medication was audited regularly by the nursing staff, this included checking stock and ensuring records were accurately kept. We asked the nurse about the systems in place for managing and handling medication and they gave us a clear, knowledgeable account of this.

Some people were prescribed medicines to be taken only 'when required,' for example painkillers. We saw plans were available that identified why these medicines were prescribed and when they should be given. The nurse we spoke with knew how to tell when people needed these medicines and gave them correctly.

Requires Improvement

Is the service effective?

Our findings

People were supported to have their assessed needs, preferences and choices met by staff that had the right skills and competencies. People who used the service and relatives we spoke with told us they thought the care staff were competent and well trained to meet their or their family member's individual needs. One relative said, "I've got no worries about the training they [the care workers] get and how they do their job." One person we spoke with said, "I think the staff know what they are doing, they all seem very nice. They are always asking me if I am alright and offer help where needed."

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. This legislation is used to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in their best interests and protect their rights. The Deprivation of Liberty Safeguards (DoLS) is aimed at making sure people are looked after in a way that does not inappropriately restrict their freedom.

We found the service to be meeting the requirements of the DoLS. The registered manager was aware of the latest guidance and was reviewing people who used the service to ensure this was being followed. We were informed that several DoLS applications had been sent to the local authority for their consideration. We saw the documentation that supported this. The registered manager told us that most staff had received training in the subject. The staff we spoke with had a good understanding of the principles of the MCA that ensured they would be able to put them into practice if needed.

We looked at the care records belonging to seven people who used the service and there was clear evidence that people were consulted about how they wanted to receive their care. Consent was gained for things related to their care. For example, we saw people had consented to the use of photographs on care plans and medical records. Two of the files we looked at were not signed by the person. We raised this with the clinical lead nurse and she informed us that they had been signed on behalf of the people as they had limited capacity, and would not understand what they were agreeing to.

People's care records showed that their day to day health needs were being met. People had access to their own GP and additionally the tissue viability nurse visited the service on a regular basis for routine treatments and to offer advice regarding wound care. Records showed that people were supported to also access other specialist services such as the diabetic clinic, audiology and dental services. The clinical lead nurse told us about a person who had restricted mobility due to their illness. They said they had arranged to have a sensory buzzer for the person which made it easier for them to alert staff when they needed assistance. This demonstrates the staff worked with other health agencies to meet people's needs.

We found that staff received supervision (one to one meetings with the registered manager) and they told us they felt supported by the registered manager, the nursing team and also their peers. The registered manager showed us a plan which told us most staff had also received their annual appraisal. Annual appraisals provide a framework to monitor performance, practice and to identify any areas for development and training to support staff to fulfil their roles and responsibilities. Staff we spoke with said they received formal and informal supervision, and also attended staff meetings to discuss work practice.

Staff told us that they attended a handover at the start of each shift which informed them of any concerns in relation to people's health. One staff member said, "I find the handover essential as I only work part-time. The information we receive gives us an overview of the health and wellbeing of people we support."

Staff had attended regular training to ensure they had the skills and competencies to meet the needs of people who used the service. The records we looked at confirmed staff had attended regular training. Most of the staff who worked at the home had also completed a nationally recognised qualification in care to levels two, and three. We saw that staff had also completed training in dementia care, Mental Capacity Act and end of life care.

The registered manager was aware that all new staff employed would be registered to complete the 'Care Certificate' which replaced the 'Common Induction Standards' in April 2015. The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

Requires Improvement

Is the service effective?

We found the service worked well with other health care agencies to ensure they followed best practice guidance. The deputy manager gave us an example of working closely with the local hospice nurses to ensure people received the best possible care when they were approaching the end of their life.

The provider had suitable arrangements in place that ensured people received nutrition and hydration that met their assessed needs. We looked at three people's care plans and found they contained detailed information on their dietary needs and the level of support they needed to ensure that they received a balanced diet. Risk assessments such as the Malnutrition Universal Screening Tool (MUST) had been used to identify specific risks associated with people's nutrition. These assessments were being reviewed on a regular basis. Where people were identified as at risk of malnutrition, referrals had been made to the dietician for specialist advice.

We used SOFI to observe a number people on two of the units who were being supported to eat at lunchtime on the first day of the inspection. We also spent time observing breakfast and tea on two of the units. From out observations we concluded that people's dining experience required improvement. People told us that they enjoyed breakfasts as there was a good choice of hot and cold food. We noted that many people had enjoyed a large breakfast and did not feel very hungry at lunchtime. We noted over the three dining areas very few people finished their meal. When we asked why they had not finished their meals some people told us they were not hungry and some said they had not liked the meal. We noted that one of the two choices of meal on offer that lunchtime was pasta bake. We saw that it was served with sprouts, carrots and mashed potato. One resident said, "That's a very weird mix." This person told us that there were often "Strange mixtures of food."

We saw that the lunchtime meals were served from a hot trolley and presented well on the plates, including the pureed meals. We noted that the dining rooms were small for the people eating in there as a number of people were sitting in profiling chairs. One person in a profiling chair asked to be moved into the lounge where there was more light and space to eat. The staff met this request. We saw that staff worked hard to meet the lunchtime needs of all the people. The dining rooms seemed quiet and it did not feel like a very social experience for people, many of whom spent a long time in the dining room.

Most people we spoke with told us the food was not very good, and sometimes the meal was not very hot when they were eating their meal. People told us the best meal was breakfast and the worst meal was tea. This was because it always seemed to be soup and sandwiches. We saw some people also had a toasted teacake instead of the sandwiches.

We discussed the meal experience with the registered manager and the clinical lead nurse. They told us they had identified this as an area that required improvements and they were considering how to make the necessary improvements. One the second day of our inspection one of the directors was present undertaking a dementia mapping exercise which included looking at people's dining experience. They have agreed to send us a copy of their findings when completed. We have since received their action plan how they intend to improve this aspect of the service.

Good

Is the service caring?

Our findings

The SOFI observation we carried out showed us there were positive interactions between the people we observed and the staff supporting them. We saw people were discretely assisted to their rooms for personal care when required; staff acknowledged when people required assistance and responded appropriately. We noted that call bells used for assistance were answered in a timely manner and most people told us that they received assistance when needed.

People told us they were happy with the care they received. We saw staff had a warm rapport with the people they cared for. Our observations found staff were kind, compassionate and caring towards the people in their care. People were treated with respect and their dignity was maintained throughout.

All of the people, relatives and visitors we spoke with told us they, or their family members or friends, received good care. They were very complimentary about the majority of the care staff. Comments about the care staff included, “They’re absolutely blooming’ marvellous, every single one!” and “You couldn’t wish for better carers – they’re just wonderful.” And “They work jolly hard and they have a laugh with you as well.” And “I think these carers are fantastic. They’ll do anything for you.”

Relatives and visitors to the home told us that there were no restrictions to the times when they visited the home. One relative said, “My family visits regularly and it is always the same. Staff are kind and considerate. They always ask how I am and tell me how my relative is.” Another relative said, “We are made to feel welcome. Everything is relaxed; staff and the nurses could not be more polite.”

We saw there were designated dignity champions. The champion’s role included ensuring staff respected people and looked at different ways to promote dignity within the home. We observed that people were treated with respect and dignity was maintained. Staff ensured toilet and bathroom doors were closed when in use. Staff were also able to explain how they supported people with personal care in their own rooms with door and curtains closed to maintain privacy. One relative we spoke with showed us the dignity tree which was in the main entrance. They had painted it onto one of the walls and told us how they were going to decorate it with comments about respect and dignity from people who lived in the home.

We looked at seven care and support plans in detail. People's needs were assessed and care and support was planned and delivered in line with their individual needs. People living at the home had their own detailed and descriptive plan of care. The care plans were written in an individual way, which included family information, how people liked to communicate, nutritional needs, likes, dislikes and what was important to them. The information covered all aspects of people’s needs, included a profile of the person and clear guidance for staff on how to meet people’s needs.

The service had a strong commitment to supporting people who used the service and their relatives, before and after bereavement. We saw the plans clearly stated how they wanted to be supported during the end stages of their life. ‘Do not attempt cardio-pulmonary resuscitation’ (DNACPR) decisions were seen on care plans and these were reviewed by their own GP.

The service had identified an end of life champions who was taking the lead on promoting positive care for people nearing the end of their life. The clinical lead nurse told us that they had undertaken specific training to ensure they had were able to support people appropriately as they approached this stage in their life.

People had chosen what they wanted to bring into the home to furnish their bedrooms. They had brought their ornaments and photographs of family and friends or other pictures for their walls. This personalised their space and supported people to orientate themselves.

Good

Is the service responsive?

Our findings

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The people we spoke with told us the standard of care they received was good. We looked at copies of seven people's assessments and care plans. They gave a clear picture of people's needs. They were person-centred in the way that they were written. For example, they included such information as people's preferences about their likes and dislikes in relation to food and leisure activities, and the times they usually liked to go to bed and to get up. People we spoke with told us they were offered choices about when to go to bed and get up, where to spend their time and what to eat. One person said, "I've always been a night owl. I like to go to bed late, so the carers always leave me till last. Then I get up a bit later than everyone else, so it works out nicely."

Some people we spoke with spent most of their time in their bedroom and they told us this was through personal choice. One person said, "I don't like watching telly in a big lounge, so I stop in here." Another person told us they were pleased because the staff had changed the position of the furniture in their room to make it more comfortable for them. They said, "They [the staff] said it was no trouble to move the bed around so I could sleep better."

We found that people's care and treatment was regularly reviewed to ensure it was up to date. Most people we spoke with said they knew a care plan was written but did not show any interest in reading it. One person said, "They (staff) told me they alter it (care plan) to suit. I think they understand perfectly what my requirements are. Not just mine, everyone's." Relatives we spoke with told us they were able to discuss any concerns with the registered manager. One relative said, "I know that I can speak to the nurses and the manager about my relatives care. They are approachable and deal with things very professionally."

People told us about a variety of activities that took place at the home, including bingo, quizzes, dominoes, craft sessions, a choir and entertainers. We also heard about a recent trip to Cleethorpes for a few people. We were told one of the activity co-ordinators brought their pet dog into the home several times a week and people enjoyed this contact. We saw that many ladies had painted nails and stylish hair do's from a regular hairdresser. People we spoke with told us they enjoyed sitting outside in the garden when the weather was fine.

People told us there was usually something going on most days and they could choose to take part if they wished. One person, who used to be a chess teacher, told us that they taught a12 year old boy chess on a regular basis and they really enjoyed that stimulation. When we returned on the second day of this visit we saw the person teaching the boy to play. Another person told us they were able to order takeaway meals at night. Staff seemed to know the preferences of people around activities and hobbies. In some bedrooms there was evidence of hobbies such as knitting, reading and puzzles.

Some people who used the service and their relatives told us there were relatives' meetings and that people could attend if they wanted to. One person told us these meetings were not well attended, but they were an opportunity to discuss issues of interest to everyone, including food. They said, "It's good to talk, but it's doing something about it that matters and I don't think the food has improved."

We saw that copies of the complaints policy were displayed throughout the home. People we spoke with mostly said they had no complaints but would speak to staff if they had any concerns. The registered manager told us that there had been four formal complaints within the past year. Our review of the provider's complaints folder confirmed this. We saw records of the complaints and how the registered manager had addresses each of them.

Good

Is the service well-led?

Our findings

People we spoke with told us they knew who was the registered manager and said they were approachable and would deal with any concerns they might have. A relative said, “The nurses are very approachable, if there is a problem they will try and resolve it, even if they are busy they will talk to you, reassure you if it’s needed.” A member of staff said, “They (managers and providers) are approachable, are really good. We can talk to them.”

The registered manager and the clinical lead nurse had a clear vision of areas that they wanted to develop to make the service better. For example, developing the care plans so they were consistent across each of the three units. They also recognised that the quality of meals needed to be improved and they sent us an action plan which outlined how they were going to do that.

The values of this service were reinforced constantly through staff discussion, supervision and behaviour. The management team told us the ethos was to provide the very best person centred care to people to help them to live their lives to the full. To do this they were supported by skilled staff who understood the importance of achieving this. Staff told us they enjoyed working at the home and wanted to provide the highest standard of care possible.

We spoke with staff about staff meetings. We were told these took place regularly. Items for discussion included issues such as staffing and people who used the service related issues, such as problems addressing particular people’s needs. We saw minutes from staff meetings which confirmed staff had the opportunity to discuss any concerns. Staff told us that the registered manager and the nursing staff were always available if they needed support.

The provider had effective quality assurance systems in place to seek the views of people who used the service, and their relatives. Surveys were returned to the provider who collated the outcomes. Any areas for improvement were discussed with staff and people who used the service to agree any actions which may need to be addressed. We looked at outcomes from the last questionnaires sent to relatives in May 2015. They showed that people were overall satisfied with the care; however there were mixed responses about the food. Some said it was good while one relative said the food was unpalatable and needed improvements.

Some comments from the relative’s surveys included, “My relative was also a resident at Moorgate Lodge until their death in January. The staff were wonderful showing them dignity and compassion and have helped mum to come to terms with her loss. I can't praise the staff too highly.” Another relative said, “Overall I am satisfied that my relative is well cared for, and that they are far better with you than in hospital. The staff are also most welcoming and supportive towards myself, and I do think that the rapport which I have established with them has been most important to me at this most difficult and tragic time of our lives.”

We looked at a number of documents which confirmed the provider managed risks to people who used the service. For example we looked at accidents and incidents which were analysed by the registered manager. They had responsibility for ensuring action was taken to reduce the risk of accidents/incidents re-occurring.

A number of audits or checks were completed on all aspects of the service provided. These included administration of medicines, health and safety, infection control, care plans and the environmental standards of the building. These audits and checks highlighted any improvements that needed to be made to raise the standard of care provided throughout the home. We saw evidence to show the improvements required were put into place immediately.

When we asked people if they would recommend the home to other friends and family, most said yes. A few people had reservations and told us that was because of the food. One person said, “It’s nothing to do with the care – that’s first class, but if you like your food it’s as well to look elsewhere.”

The service had good working relationships with other organisations and health agencies. The local council who also monitors the service told us they had agreed an action plan which they were monitoring the progress. They said they were due to visit the home again to review the plan.

We spoke with a psychologist who was visiting one of the people who used the service. They spoke very positively in relation to the home and the service that it provides to individuals. However, they did state that at times it was ”Sometimes difficult to locate staff” when they visited the

Good

Is the service well-led?

home. They stated that following their visit they always reported back to the staff on duty in relation to what had been discussed and arrangements that had been made for the next visit.