Anchor Carehomes Limited

Oak Tree Lodge

Inspection report

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Date of inspection visit:
21 June 2017
22 June 2017

Date of publication:
03 August 2017

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 was an unannounced inspection carried out on 21 and 22 June 2017. At the last inspection we found that there was a lack of management oversight at the service and that there was not a robust programme of activities. Furthermore we found that the building was not properly maintained and that staff did not receive appropriate support and supervision. At this inspection we found improvements had been made in all these areas.

Oak Tree Lodge is situated in the Harehills area of Leeds. It is a purpose built home with 60 beds, providing care for older people and people living with a dementia related condition. There were 59 people living at the service at the time of inspection. The building was split into three floors, with the ground and first floor catered towards people living with a dementia related condition, and the top floor was for people requiring personal care and accommodation. The building was wheelchair accessible with lift access to all floors, and the building was secured with keypad entry.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe in the home. There were enough staff to deliver care safely, and staff had appropriate training. Staff had a good understanding of safeguarding vulnerable adults. People had plans in place to manage risks, which were understood by staff.

People received their medicines safely and as prescribed. Medication Administration Records (MAR charts) accurately recorded prescribed medications delivered and medicines were stored safely. People had regular and appropriate access to health professionals to meet their needs. Staff worked in partnership with health professionals who had no concerns with care provided at the service.

There were adequate recruitment processes in place to ensure staff were recruited safely and that they were suitable to meet people's needs. Staff had sufficient training to ensure they could carry out their roles effectively. Staff were supported with regular appraisals, and the service was starting a new appraisals process to enhance existing mechanisms.

There were policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005. Staff were trained in the principles of the MCA and could describe how people were supported to make decisions; and where people did not have the capacity; decisions were made in their best interests.

People received support from kind and compassionate staff who understood their individual needs. Care plans were person centred and evidenced input from people and their relatives.

People were supported to eat and drink safely and there was evidence people were able to choose what they wanted. If people did not like the options, kitchen staff were able to prepare alternatives from a well-stocked pantry containing fresh produce. People's weight was monitored and nutritional risk assessed appropriately.

There were systems in place for people to raise any concerns, and we saw evidence that complaints were responded to, in line with the provider's policy in a timely and appropriate way.

There was an appropriate programme of meaningful activities for people delivered by staff, and people's participation was recorded. People were able to access the community and people's ideas and suggestions were listened to and acted upon. We saw that the service asked people what they thought of their care and that their views generated actions taken by the service to address them.

There was a clear leadership structure with the registered manager holding oversight of governance arrangements. The registered manager provided clear leadership, and staff understood their roles and what was expected of them. We saw that there was an effective quality assurance process, with a range of audits and monitoring systems in place to ensure quality of care was maintained and the environment of the home was safe.

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 building and premises were adequately maintained by trained staff and was pleasantly presented.

There were adequate levels of trained staff to provide safe care.

People felt safe at the service, and staff knew how to raise safeguarding notifications appropriately.

People were given their medicines safely. Prescribed medicines were stored and recorded appropriately.

Is the service effective?

Good

The service was effective.

People were cared for by competent and knowledgeable staff who were supported with their training needs.

People were supported to maintain sufficient levels of nutrition and hydration by staff who understood how to meet people's different dietary needs.

People had access to external healthcare professionals, and staff knew how to make referrals appropriately.

Is the service caring?

Good

The service was caring.

The service was caring.

Staff had a good rapport with people, and the atmosphere was relaxed and happy.

Staff treated people with dignity and respect.

People were involved in their care and gave positive feedback about the care they received.

Is the service responsive?

Good

The service was responsive.

Care records were easy to follow and person centred, with regular reviews to ensure they were fit for purpose.

There was a programme of activities provided by staff with people's preferences and personalities taken into account.

People knew how to raise concerns and complaints were dealt with appropriately.

Is the service well-led?

Good

The service was well led.

The registered manager provided effective leadership and was supported by the provider.

Staff felt well supported by the management team.

The service had appropriate quality assurances systems and processes in place to ensure people were not put at risk and improvements could be identified.

Oak Tree 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 was an unannounced inspection carried out on 21 and 22 June 2017.
The inspection team consisted of two CQC inspectors.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports and statutory notifications sent to us by the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before the inspection providers are asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not ask the service to provide us with a PIR prior to this inspection.

At the time of our inspection there were 59 people using the service. During our visit we spoke with three people who used the service, three relatives and seven staff which included the registered manager, deputy manager, kitchen staff, maintenance staff and carers. We also spoke with two visiting health professionals. During the inspection we spent time observing interactions between people and staff, looked around the home which included some people's bedrooms and communal areas and observed care being given. We looked at relevant documentation and records that related to the management of the home. We also looked at four people's care plans.

Good

Is the service safe?

Our findings

At our last inspection in April 2016 we found that people were not always safe, with malodours and clinical waste identified as concerns. At this inspection we found that the service had made the required improvements.

At our last inspection in April 2016 we found that there were issues around the maintenance and cleanliness of the building, with malodours noted, hazardous waste overflowing and no designated maintenance staff member employed at the home. We concluded at that time that this was a breach of Regulation 15 of the Health and Social Care Act. At this inspection, we saw that the service had recruited a dedicated maintenance staff member, hazardous waste was secured in an enclosed and locked area and appropriate hazardous waste disposal checks were made. We saw that there were systems and processes in place to monitor the facilities and equipment and appropriate checks had been undertaken. The maintenance staff member had recently been accredited to conduct portable appliance testing and at the time of inspection was conducting a programme of checks to certify all appliances as tested.

People were supported with their medicines by staff who administered them safely and as prescribed. A person we spoke with told us their medicines were always given to them without any issues and that if they required additional medicine, for example painkillers, they received them promptly. We saw evidence in care plans that people's preferences as to how they liked to take their medicines were documented, for example, "[Name] likes their medicine with a glass of water and their Calcium tablet last." We carried out observations which evidenced staff asked people if they required painkillers.

We saw that the provider had systems in place to ensure that medicines were managed appropriately. This included how medicines were received, stored, recorded and returned when necessary. Daily records were maintained by staff showing when people had received their medicines as prescribed. However we saw two occasions when people had received paracetamol from staff and staff had not always documented the time of administration. This was important as paracetamol has to be given with at least four hour intervals between administration. We spoke with the team leader who told us they would ensure this was always recorded in the future. When we raised this with management they accepted these as actions and we saw this was included on a management action plan on the second day of our inspection. A staff member we spoke with was able to explain to us the process they went through for managing and administering medicines for people.

The service was regularly audited by an external provider who did not raise any concerns with regards to medicines administration practice. Staff had been trained to deliver medicines appropriately by an external pharmacist and certificates were recorded in their personnel files.

People we spoke with told us they felt safe in the home and we saw that people looked relaxed in the company of staff. One person we spoke with said, "I really like it here, no problems at all." A relative we spoke with said, "Me and my sister can now sleep at night knowing our mother is safe." They continued, "I know my mother wants to be here."

We saw that the provider had processes in place to support staff with information if they had concerns about people's safety and how to report those concerns. Staff we spoke with told us that they received regular training on keeping people safe from abuse and avoidable harm and could recognise the different types of abuse. Staff members we spoke with gave us examples of the signs that might identify if someone was being abused and that they would alert a senior member of staff or the registered manager. Staff knew when and how to raise safeguarding alerts appropriately. We saw effective oversight and governance of safeguarding, for example where the provider found a high number of safeguarding referrals made within a short time period, the area manager initiated a safeguarding review. This review was able to identify any themes or trends, and an action plan was agreed with the registered manager and the area manager.

We saw there were enough staff to deliver care safely. The service used a dependency tool to calculate the level of staff required for each shift in order to meet the needs of people using the service. At our inspection staff were visible around the home and people were relaxed in the company of staff. The provider reviewed staffing levels monthly, and we found that they met and sometimes exceeded the requirements set out by the dependency tool. The service had some vacancies at the time of the inspection. The service responded to this by using agency workers and staff to covering shifts.

Staff were recruited safely and appropriately. We saw there was a thorough interview process and photo identification, at least two professional references and Disclosure and Barring Service (DBS) checks were present in the personnel files we reviewed. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with people who use care and support services. In addition, the registered manager told us how risk assessments were used to further ensure that staff were recruited appropriately, for example they told us one instance where an offer of employment was rescinded when a DBS check revealed information that the registered manager felt made that person unsuitable for the service. The registered manager was supported in this decision by the provider and the person was not employed.

We saw that staff acted in an appropriate way to keep people safe and were knowledgeable about the potential risks to people. Risk assessments were reviewed monthly. A member of staff told us, "We identify risk with people when they are admitted to the home, then we monitor and make any changes if their needs change." The provider carried out regular risk assessments which involved the person, their family and staff. We saw that risk assessments were updated regularly in care plans. Everybody using the service had an individual personal emergency evacuation plan which was detailed and person centred. For example where an individual had good mobility but needed encouragement and instruction due to their condition, this was clearly identified in the plan. The service also had a business continuity plan which contained guidance and a delegation of authority in the event of an emergency.

The environment was pleasantly decorated with lots of room for people to walk around and an abundance of quiet spaces. The home was clean at the time of the inspection. We saw that different rooms had themes, such as a fifties-style diner, a coffee shop and a cinema. Corridors were spacious with plenty of seating areas and sufficient lighting. At the end of corridors, communal areas had large bay windows so people could have a good view of the surrounding area and garden. Although the building was secured by keypad entry, people were encouraged to move between floors. For example when there was an entertainer on a specific floor, we saw that residents from other floors were encouraged to join in and were helped with their mobility so that they could participate if they wanted to. Communal toilets were clean, tidy and well signed, with access for people with disabilities. People's bedrooms were personalised, with storage for their personal belongings.

Good

Is the service effective?

Our findings

At the last inspection in April 2016 we found that the service was not always effective because staff did not receive appropriate support through appraisals and supervisions in line with the provider's policy. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act. At this inspection, we found that the provider had made the required improvements.

There was an effective and competent staff team at the service. New staff followed a three month induction process which was recorded in an induction log book. This detailed what training had been undertaken with free text boxes to add further information and comments from the registered manager. The induction programme included modules such as orientation to the service and introductions to service users. We saw that all training modules completed had certificates printed and placed in personnel files. There was a six month probationary period for new staff with regular meetings.

The service provided a comprehensive programme of training in line with the provider policy and the service used a training matrix to record each staff members training history to identify gaps. The target set by the provider for mandatory training completion across the service was 80%; at the time of the inspection 81% of staff had completed all mandatory training. The registered manager told us the next step was to move this target to 90%. We were told that where training required face-to-face or external providers, these were in the process of being booked and we saw evidence that this had happened in the past. The training matrix generated an action plan where gaps were identified, and we saw that where medications training had been seen as an outlier in January, the service had acted and 100% of staff had now completed safe administration of medicines training with the help of an external provider. One staff member we spoke with said, "I'm happy with the training, there are all sorts." Another member of staff agreed and said, "I can go on courses if I want to." We saw evidence that staff had been promoted internally to positions such as team leader and deputy manager.

Staff told us they had regular supervision and appraisals to support their development. A staff member we spoke with told us, "I'm happy with them [supervisions], I get to say what I want to say." We found that the service had implemented a new supervisions programme from April 2017, where the first supervision set out objectives for the financial year. We saw an example of a completed supervision which recorded role-specific objectives, personal evaluation by the registered manager, changes to DBS status, objectives set out by the staff member, behaviours met against the provider's values, a development plan and an overall evaluation of the previous year's performance. We were shown a supervision matrix that showed nearly all staff had their new supervision completed and all staff had recorded at least one supervision since January 2017. Another staff member told us, "We had supervisions this year, there was one point I didn't agree with but it was changed [after I challenged it]." We concluded that the service had a robust supervision process and that the service had met the requirements of the breach of Regulation 18 found at the last inspection.

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. Not all of the people who lived at the home had the mental capacity to make informed choices and decisions about all aspects of their lives. We saw some people had mental capacity assessments and when decisions were to be made for someone who lacked capacity, we saw best interest meetings had been held. Staff we spoke to told us they had been trained in the Mental Capacity Act 2005, one member of staff we spoke with said, "We all have to go through the training." Staff told us they understood about acting in a person's best interests and how they would support people to make informed decisions. We saw staff asking people's permission before supporting them with their care and support needs. For example; some people were asked if they wanted any painkillers and their choice was respected. A member of staff we spoke with told us how they gained consent from a person who may have had fluctuating capacity. This showed us people made their own choices as far 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that people's capacity had been assessed and that the provider had made appropriate DoLS applications to the Local Authority.

People were supported to maintain good levels of nutrition and hydration with choice from a healthy and varied menu. We observed a midday mealtime at the service. The tables in the dining area were laid out in restaurant style with tablecloths set and condiments available. Staff used personal protective equipment and washed their hands before serving food. The meal had three courses, with a soup starter, a choice of two mains (one hot and one cold) and a choice of two desserts. People were offered either option visually with plated examples to encourage them to make independent decisions. A staff member we spoke with told us how they discussed menu choices with people on a regular basis to ensure they ate the food they preferred. These communications were logged and actioned with requests made to the supplier to make changes to the menu, which was seasonal. People were offered refreshments continually throughout mealtime; one person we spoke with told us there were always plenty of drinks available, they also said, "The food is lovely." Staff said if people did not want what was available that kitchen staff would accommodate requests from their 'core' menu which included items like jacket potatoes and omelettes. This was verified by the head chef who had a well-stocked pantry with fresh produce available.

Staff interactions were positive, kind and caring, with staff meeting service users at eye level and gently encouraging them to eat or offering alternatives when food was refused. Music was played throughout the service at an appropriate level, adding to a friendly and warm atmosphere. Residents were visibly relaxed and engaged with each other as well as staff.

There were snacks and refreshments available at all times during the day. People were provided with home baked cakes and biscuits daily. Kitchen staff were knowledgeable about different dietary requirements such as fork-mashable and pureed food. People requiring soft foods received their meal in line with their needs. The kitchen held a log of each service user and their dietary requirements, allergies and general likes or dislikes which was regularly updated by the deputy manager. We were told that the supplier was able to accommodate religious and cultural needs. Kitchen staff received feedback from team leaders meetings, and by going to each floor and asking people what they thought. A member of the kitchen team told us "I love my job. I'm getting to know the residents; I go on the floor every day [after service]".

People who used the service were weighed monthly and where weight losses totalled more than 2kg in one instance or there was a trend of falling weight over time, a malnutrition universal screening tool (MUST) score was completed and weight monitored weekly. Actions were then generated when people's weight fell. We saw one instance where one person lost more than 2kg but there was no evidence of any actions taken

on the monthly weight record. When we raised this with the registered manager they told us that they believed this was a misreading and that another weight check was arranged which showed that the person had not lost weight. The registered manager accepted that there was scope for the monitoring forms to include extra space for context to be provided if there was a non-medical reason for weight loss such as a misreading, however we were satisfied that this assessment was correct and saw the records to confirm this.

People had access to health professionals. The registered manager told us when somebody had in injury to their head or complained of pain then 999 would be called automatically. The registered manager told us that as a result of an incident, carers were encouraged to call 999 themselves if they felt that someone was in need of care even if their team leader disagreed. People we spoke with also told us that their health needs were being met. One person told us, "The doctor and nurses come in all the time." We saw from care plans that people were supported to access a variety of health and social care professionals. For example, dentists, opticians and GP's, as required, so that their health care needs were met and monitored regularly. Two local GP services held surgeries where health professionals visited the home to address any health concerns and monitor people's clinical wellbeing.

We spoke with two visiting health professionals to confirm our observations that people had appropriate access to health professionals and that they were cared for by professional, trained staff. Both held positive opinions of the service. One professional said that it was their "Favourite home" to visit as it was well organised and that staff knew when to make necessary referrals. They told us that, "Visiting 30 people here is much easier than visiting far less at other care homes." They told us staff took directions from health professionals well and were unafraid to prompt district nurses where necessary when they felt healthcare needs were not being met. Another health professional told us that in one instance where a GP had made an incorrect prescription; care staff themselves recognised this and notified the GP that it was an incorrect dose. They also agreed that the care home was, "One of the better ones" and that staff were 'hot' on the issue of medicines.

Good

Is the service caring?

Our findings

We noted the atmosphere in the home was warm and welcoming. From our observations we saw that people were relaxed in the presence of staff and appeared to be happy. We saw that staff were attentive and had a kind and caring approach towards people. A person said to us, "It's wonderful here. You can always have a laugh and a giggle with the girls [staff]." A relative we spoke with said, "The staff know what they are doing, they are great. The whole family could not be happier. They treat mum so well." They went on to explain how, when their family member was unwell, a member of staff had been in contact to keep them up to speed. A member of staff we spoke with told us, "I rate the care we provide as ten out of ten."

We saw that people were supported to make decisions about what they did, where they went and what they liked to do. One person we spoke with told us how they enjoyed singing with their friend. They told us, "The singer's here so I'll see you later." During our visit we saw people making choices about what they were doing, either in the communal lounge or their own rooms. We found that staff often recorded these interactions in their individual activity logbooks. We saw staff explaining what different foods were on the menu to help people make choices about what they would like to eat and offering 'show' plates of different options, as well as suggesting alternatives when people did not want either option.

Staff told us how they supported people to be as independent as possible. A member of staff we spoke with said, "[Name] can wash themselves but they sometimes need help with their back and hair." We also saw this reflected in people's care plans, for example where people had the ability to do things for themselves such as apply make-up, this was noted and encouraged. This meant that people's dignity was maintained as much as possible when people needed help with their personal care.

We asked staff how they would ensure people had their privacy and dignity maintained and respected. Staff gave us an example that they would prioritise discretion, offer support and "Not shout it across the room" so as not to make others aware. They told us that when assisting with personal care, they would, "Always knock before entering, close all curtains and doors and place towels over people" to ensure dignity was maintained. We saw that dignity was a topic of discussion at staff meetings.

Throughout the day we saw people moving around the home independently, and doing things for themselves, for example one person we spoke with showed us around their bedroom. This demonstrated that people could make decisions for themselves regarding what they wanted to do throughout the day, promoting their independence. Everyone we spoke with told us there were no restrictions on visiting times, apart from the mealtimes which were 'protected' to enable people to have their nutrition and hydration monitored. A relative we spoke with told us, "You can come anytime; it's nice to get involved with the entertainment with [Name]." This demonstrated that people were supported to maintain contact with people who were important to them.

We saw no evidence to suggest that the service was not meeting its obligations under the Equality Act (2010) to protect people's diverse needs such as gender, race, disability, sexuality and religion. People's wishes were respected and their needs recorded sensitively. For example where people preferred female care givers

for assistance with washing and dressing, this was noted in their care plans. People's religious and cultural wishes were also noted in their care plans.

We saw end of life care was discussed and recorded sensitively in people's care plans. Their religious choices were detailed, however where people did not want to discuss end of life care this was also respected and noted for follow up at a later date. We saw evidence that people's relatives were included in discussions around end of life.

The service held a compliments folder. Relatives praised the service for their care and compassion in looking after their relatives who had passed away. A visiting health professional told us that for a recently deceased service user, end of life care was in their opinion, "Extremely good." We saw an end of life care plan that was amended to reflect the fact that a person was at end of life and adjustments were made appropriately and sensitively.

Good

Is the service responsive?

Our findings

At our last inspection in April 2016 we found that the service was not always responsive to people's needs and that people were not provided with stimulating and meaningful activity. At this inspection we found that the service had made the required improvements.

At our last inspection we found the service did not have a robust activities programme; this was a breach of Regulation 9 of the Health and Social Care Act. At this inspection we found that the service had implemented a robust activities programme. Staff delivered activities and recorded them in a log book. Each service user had an individual activities record book which showed when somebody had been offered to take part in an activity, who had offered, what their response was, and a choice of smiley faces to indicate whether this interaction was positive, neutral or negative. Staff were knowledgeable about what service users liked and did not like. For example on the second floor residential area staff told us people did not generally take part in activities requiring interaction, but they did enjoy singers and musicians. This was reflected in the activities log book which showed activities being offered and declined, but their alternative preferences were noted, for example 'wanted to watch TV instead.' We saw that positive conversations and interactions were also logged as activities. A staff member told us, "Things have got better since the last CQC report, before the only activities were provided by external entertainers and staff didn't do any. Now we have a log book and each resident has a sheet."

There was a weekly activities programme in addition to external entertainers and trips outside. Activities included arts and crafts, reminiscence with photographs, coffee afternoons and film evenings in the cinema room. On the day of our inspection we witnessed service users being taken outside to the park by care staff (which we saw was raised by people as something they wanted to do through residents meetings). We also saw an entertainer engaging people in sing-alongs and quizzes, which was well attended by people who lived across all three floors and we also saw a musician performing. The registered manager showed us photographs of care staff and people outside and on trips in the community (for example to a local café and park) to show people's relatives evidence that activities had taken place and that people were meaningfully stimulated and supported.

Activities log books contained advice from the Alzheimer's society on how to engage people who had dementia effectively and appropriately during activities. However, some staff told us that on occasions activities were disrupted by incidents or other urgent care needs where care staff would prioritise this over activities delivery. Staff told us that disruption to activities happened, "About once every fortnight" but they would always attempt to deliver other activities throughout the day and we saw no evidence to suggest that regular activities were not taking place or that people were left without opportunities to take part in activities.

There was an effective admissions process in place to assess people's needs and suitability for entry into the service. People were asked about their personal details, life story, religious and cultural background, health questions, and questions around their current care needs, for example personal care and mobility. An initial enquiry was followed up by a formal discussion and a tour of the premises. This ensured that people were

admitted appropriately.

We found that staff treated people as individuals and provided good person centred care. We saw a person being asked by a member of staff if they would like a cup of coffee, they said, "Yes, and I'd like a piece of toast too" which was promptly provided. There was good rapport between them and we could see that they were comfortable in each other's company. Another person we spoke with told us they had preferences of how they started their day. They told us that they stayed in their room until they had their personal care support. They preferred a shower to taking a bath; once this had been done they were supported down to the lounge area. Staff we spoke with understood the importance of providing personalised care, and told us that they asked people how much support they required when washing themselves. Another member of staff we spoke with told us, "You get to know people's likes and dislikes. Everybody likes thing done in certain ways." We saw detailed, personalised care plans that identified how people liked to receive their care and people and their relatives told us that they could discuss any issues with staff and the registered manager.

We saw care records had been created in partnership with people who used the service. Relatives we spoke with also told us they were asked about people's backgrounds, likes and preferences to enter into the care records. We read through care records and found they included personalised, specific information for each person. For example preferences included if people preferred tea or coffee, bath or shower and any other preferences that were important to them. Care records were easy to read and organised well. Records had been reviewed on a regular basis and reflected people's current needs. Staff told us the records were up to date and easy to use.

We observed staff responding to people's needs promptly when required throughout the day. For example we saw a person requested a snack and a drink. A staff member offered them some crisps or if they wanted to wait a short while there would be cake. The person asked for crisps and staff got them their snack immediately. A staff member we spoke with told us that, "We are really person centred here. Staff know people's preferences".

The service had an up to date complaints policy and in the reception area there was advice on how to complain through the service and also how to complain to the Care Quality Commission (CQC). We reviewed the complaints file and found that there were no trends or themes; however the responses were timely and appropriate. In one instance we saw that a complaint had triggered a safeguarding referral and internal investigation, which showed that the service was responsive to people's complaints.

The service provided opportunities for people to provide feedback about the service and acted on the information received. We saw that there were regular monthly residents meetings held on each floor which included topics of discussions such as food and activities. There were also other events which were designed to capture service user voice, for example the service held a wine and cheese night which we were told was poorly attended so the service subsequently held a buffet evening which was well attended, and as a result of people's comments recorded during the meeting an action plan was formulated and acted upon.

The service had a 'you said, we did' board to show how they responded to what people said, where suggestions from each floor were paired with actions taken by the service. For example, where bigger jigsaw puzzles were requested, these were purchased by the service, and where a cocktail night had been suggested, we saw plans were in place for this and alcohol had been purchased in advance of the event.

Good

Is the service well-led?

Our findings

At our last inspection in April 2016 we found that the service was not always well led, and there was a lack of oversight from the registered manager concerning governance systems. At this inspection we found that the service had made the required improvements.

There was a regular programme of audits and quality assurance processes throughout the service to ensure governance and oversight was appropriate and where trends and themes were identified, support could be accessed. For example, the registered manager used an electronic system to submit a weekly report of falls, pressure ulcers and infectious diseases, which was then analysed by the provider who assessed the level of risk and suggested actions. Responsibility for audits was shared across the team, for example the head chef was responsible for kitchen audits and the head of maintenance was responsible for auditing health and safety checks. The registered manager was directly accountable for these and reviewed the audits to ensure they were accurate.

At our last inspection, we found that the provider failed to notify CQC appropriately and that this was a breach of Regulation 17 (good governance) of the Health and Social Care Act. At this inspection, we saw that notifications and safeguarding incidents were submitted appropriately and records on file matched. Therefore the service had met the conditions of the breach. Accidents and incidents were recorded appropriately in people's care plans and relevant notifications submitted to CQC.

There was a registered manager in post who was supported by deputies and team leaders. The registered manager had access to support from the provider and area manager. One staff member told us, "I'm confident in the manager, they are very approachable." Another staff member said that, "There is good management support. The registered manager is supportive and very approachable."

Staff told us they enjoyed working at the service. All staff we spoke with said that they would be happy for their loved ones or relatives to live at the service. One staff member said, "I'd love my nan to come live here." Staff told us they felt there was an open culture, and that the registered manager was approachable and receptive to staff ideas. We reviewed staff meeting minutes which recorded evidence of staff constructively challenging the registered manager and raising ideas. Staff told us that team meetings were conducted on a regular basis. We reviewed the notes from the last team meeting and saw staff were asked for their opinion on some matters and suggested ideas. There was also a record of staff raising their concerns and these were responded to by the registered manager. This showed us staff had the chance to raise concerns or ideas to improve the service. A member of staff told us that, "They [Registered manager and deputy manager] are always up for new ideas and receptive to staff input."

The service had a register of up to date corporate policies and each month the registered manager circulated a chosen 'policy of the month' for staff to read. There was an up to date whistleblowing policy. A staff member we spoke with told us that they knew the number to call in line with the whistleblowing policy. We also saw the registered manager challenging staff members in staff meeting minutes where they felt practice was not up to standard. Furthermore, we reviewed an on-going disciplinary process which we

found to be robust. Therefore we concluded that there was evidence staff were confident in challenging behaviour they found inappropriate, and that staff were challenged by the management team fairly which demonstrated a good organisational culture.

We also saw that the registered manager had their own personal action plan which was generated from a variety of sources, including their self-assessment, area manager visits, audits and CQC visits. We concluded therefore that there was good oversight of governance and adequate systems and processes in place.

People who used the service and their relatives were asked for their views on the care offered at the service. An external provider sent an annual questionnaire to people and their relatives on behalf of the service and analysed the returned information for trends and themes. At the last survey, 15 people and 19 relatives of service users participated. The results of the survey were positive, and they were compared nationally with other homes operated by the provider. The service performed similarly to the provider's average satisfaction rate. At the previous survey in 2015, the overall engagement score (which was calculated by analysing the responses to each question given) was 48%. For the 2016 survey, this had improved to 76%, in line with the provider average.