Brownlow Enterprises Limited

Aronmore Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection was carried out on 5 and 6 September 2016. This was a comprehensive inspection that was brought forward due to concerns raised around people's safety and shortfalls identified by the local authority. The service was last inspected on 18 and 20 May 2016 and was compliant in all domains.

Aronmore Residential Care Home provides accommodation with personal care for up to a maximum of 31 people. The service consists of a 27 bedded care home and there are four individual 'cottages' in the rear grounds of the service. At the time of our inspection there were 29 people living at the service, one of whom was in hospital.

The service is required to have a registered manager. 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. The registered manager had been registered with CQC since 3 August 2016 and had recently taken over managing the service full time. They are an experienced manager who had previously managed two other services owned by the provider.

We found some shortfalls with medicine stock balances and recording so medicines were not always being safely managed. The registered manager addressed the finding at the time of inspection and said she would increase medicines monitoring so issues were promptly identified and dealt with.

There was limited evidence of people's input with their care records and people did not know about their care records. The registered manager was aware and said this would be addressed.

People and relatives expressed their satisfaction with the care and support being provided.

Systems were in place to safeguard people from the risk of abuse and staff understood the action to take if they suspected abuse.

Risk assessments were in place for identified areas of risk to minimise them. Systems and equipment were serviced and maintained to maintain their safety.

Staff recruitment procedures were in place and being followed. There were enough staff on duty to meet people's needs and recruitment was ongoing.

Staff received training to provide them with the skills and knowledge to care for people effectively.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS were in place to ensure that people's freedom was not unduly

restricted. Staff acted in people's best interests to ensure their freedom was not unduly restricted.

People's nutritional needs were assessed and monitored. People's dietary needs and preferences were being identified and met.

People's healthcare needs were identified and they were referred to the GP, community nurse and other healthcare professionals when required.

Staff understood the individual care and support people needed and provided this in a gentle and caring manner.

Staff respected people's choices and treated people in a respectful and dignified way.

Care records were personalised and up to date and changes in people's condition had been identified and included in the care plans.

People and relatives were confident to raise any complaints and systems were in place and being followed to record and investigate these.

The registered manager had recently taken over managing the service and demonstrated the knowledge and skills to do so effectively. The registered manager was approachable and listened to people and staff, taking action to address any issues promptly and to promote good practices.

Systems were in place to monitor the quality of the service and the registered manager was expanding these to ensure all aspects of the service were monitored. Work in this area was ongoing, with environmental improvements being planned for the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. We found some shortfalls with medicine stock balances and recording so medicines were not always being safely managed. The registered manager took action to address our findings.

Systems were in place to safeguard people from the risk of abuse and staff understood the action to take if they suspected abuse.

Risk assessments were in place for identified areas of risk to minimise them. Systems and equipment were serviced and maintained to maintain their safety.

Staff recruitment procedures were in place and being followed. There were enough staff on duty to meet people's needs and recruitment was ongoing.

Is the service effective?

Good

The service was effective. Staff received training to provide them with the skills and knowledge to care for people effectively.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS were in place to ensure that people's freedom was not unduly restricted. Staff acted in people's best interests to ensure their freedom was not unduly restricted.

People's nutritional needs were assessed and monitored. People's dietary needs and preferences were being identified and met.

People's healthcare needs were identified and they were referred to the GP, community nurse and other healthcare professionals when required.

Is the service caring?

Good

The service was caring. Staff understood the individual care and support people needed and provided this in a gentle and caring manner.

Staff respected people's choices and treated people in a respectful and dignified way.

Is the service responsive?

Requires Improvement

The service was not always responsive. There was limited evidence of people's input with their care records and people did not know about their care records. The registered manager was aware and said this would be addressed.

Care records were person-centred and reflected changes in people's needs. Work was ongoing to improve the activities provision in the service.

People and relatives were confident to raise any complaints and systems were in place and being followed to record and investigate these.

Is the service well-led?

Good

The service was well led. The registered manager had recently taken over managing the service and had the knowledge and skills to do so effectively. The registered manager was approachable and listened to people and staff, taking action to address any issues and to promote good practices.

Systems were in place to monitor the quality of the service and the registered manager was expanding these to ensure all aspects of the service were monitored. Work in this area was ongoing, with environmental improvements being planned for the service.

Aronmore Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 5 and 6 September 2016 and the first day of inspection was unannounced. Before the inspection we reviewed the information we held about the service including notifications and information received from the local authority. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The inspection team consisted of two inspectors.

During the inspection we viewed a variety of records including five care records, some in detail and some to look at specific areas of care, the medicine supplies and medicines administration record charts for 11 people, five staff recruitment files, risk assessments for individuals and safe working practices, servicing and maintenance records for equipment and premises, complaints and safeguarding records, audit and monitoring reports and policies and procedures.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the mealtime experience for people and interaction between people using the service and staff.

We spoke with five people using the service, two relatives, the registered manager, two senior care staff, three care staff, two catering staff, one of whom also carried out domestic duties. We also spoke with a visiting healthcare professional a visiting support worker and a Church representative. Following the inspection we requested and received feedback from two healthcare professionals and from the provider.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always being managed safely. On the first day of inspection we carried out a stock check of three boxed medicines for one person. For two medicines there was a discrepancy between the number in stock and the number that had been signed for on the medicine administration records (MARs) as having been given. The registered manager carried out an investigation and on the second day of inspection was able to account for the medicines following a wider stock check and review of care records. We also noted that for 'as required' (PRN) medicines the number of tablets in stock had not been carried forward from one month to the next, so it was not possible to carry out an accurate stock check. The registered manager said she would increase the medicine audits so any shortfalls were promptly identified and addressed.

For one person a PRN medicine had continued to be ordered despite the person only requiring it occasionally and as a result stock supplies had been high and the excess had been returned to the dispensing pharmacist. The registered manager said she would address this so medicines were not ordered if they were not required. For some boxed medicines instructions on the MARs did not include any specific instructions, for example one stated, 'apply as directed' and another said 'one to be taken weekly'. The registered manager said she would speak with the GPs and the dispensing pharmacist to address this issue. We noted that staff had added accurate instructions about the frequency of the application of creams and for the administration of the weekly medicine alongside the MARs.

People who commented were happy with the way they received their medicines. One person said, "They are very well organised as far as I can see." Staff involved with the administration of medicines had received training in medicines management and they understood the safe administration of medicines. Medicine administration record charts (MARs) were supplied by the dispensing pharmacist and were signed by staff each time a medicine was administered. We viewed the MARs for 11 people living at the service and these were complete and up to date. Where a medicine had not been given a coding had been used to identify the reason why it had been omitted.

The service used a blister 'pod' system and medicines were supplied every 28 days in four separate seven day packs. Information sheets were available for each person and included a picture and description of each medicine. Some medicines were supplied in the original boxes or in bottles. We checked the blister pods and boxed or bottled medicines for 11 people using the service and apart from the shortfalls already described, the stocks tallied with the numbers given and the records were being maintained. Identification sheets were kept with the MARs and these included a photo of the person, their name and room number. Allergies were identified on the MARs.

For people on anticoagulant medicines we saw the most recent letter from the clinic with the dose to be given was being kept next to the MAR and staff ensured the correct dose was given. We did a stock check of three anticoagulant medicines and the stocks tallied with the number of tablets given. Protocols were in place for PRN medicines and these provided clear information for staff including when the medicine should be given, dose and frequency. Liquid medicines, creams and eye drops had been dated when opened. Temperature checks were carried out for the medicines trolley, the medicines storage cupboard and the

medicines fridge and these were all within the identified safe ranges for medicine storage.

We asked people and their relatives if they felt safe at the service. Comments included,
"I always tell them when I am going out.", "You know you are listened to and you are safe.",
"It's good because they look after you. I feel absolutely safe.", "You are protected and you know you're safe" and "[person] is safe here. They do a really good job."

People were being protected from the risk of abuse. We asked staff what they understood about safeguarding. Staff told us they had received training in safeguarding and described the different types of abuse. We asked what they would do if they found an unexplained injury, for example, a bruise and they knew to record the finding and identify the bruise on a body map form and report it to the senior on duty or the registered manager. We asked staff about whistleblowing and one member of staff told us, "If something is wrong I tell the manager and if the manager is not doing something I go to [provider]. If [provider] isn't doing anything I would call CQC." Another said, "If I see the manager is not taking measures I would go to [provider] and if nothing happened go to social worker or CQC." Policies and procedures for safeguarding and whistleblowing were in place and staff knew the action to take to report any suspicions of abuse. Staff understood whistleblowing procedures and knew the outside agencies they could contact to report concerns including the Care Quality Commission and the local authority.

Staff understood the importance of maintaining people's safety. Comments included, "Try to make the hoist comfortable for them. You need to use the right hoist sling for the person's size" and "It is important to read care plans to know what's safe for people." Risks were assessed so they were identified and action could be taken to keep people safe. Individual risk assessments had been carried out and included those for developing pressure sores, falls, nutrition, confusion, moving and handling risks including use of hoist and slings in the event of a fall and risk of absconding. There were also risk assessments for people's healthcare needs, for example, risks associated with diabetes and poor eyesight. Risk assessments for safe working practices including use of COSHH (control of substances hazardous to health) products, use of moving and handling equipment and guidance, and cleaning of kitchen equipment. There was also a workplace environmental risk report to identify any risks. We discussed ensuring all areas of risk within the service were identified and assessed and the registered manager said she would review this to ensure all areas were included.

There was a fire risk assessment for the whole building and people had individual risk assessments for personal fire evacuation risk and fire doors so the risks were identified, action could be taken to minimise them and the information was available to share with the emergency services. Fire checks were carried out weekly and recorded. These included fire escape routes, emergency lighting, fire extinguishers and fire alarm testing. A fire drill had been carried out in August 2016 to include evacuation of the building. The registered manager said these would be being carried out regularly to familiarise people and staff with the procedures. Servicing and maintenance records had been completed and we saw systems and equipment including gas appliances, call bell system, hoists and fire safety equipment were being serviced at required intervals. Accidents and incidents were being recorded and there was a report log for all significant accidents, which the registered manager reviewed to look for any trends so these could be addressed, for example, getting people referred to the falls clinic to help manage their falls.

Employment checks were carried out to ensure only suitable staff were employed at the service. Staff had completed application forms and pre-employment checks had been carried out. These included a minimum of two references, including one from their previous employer, a Disclosure and Barring Service (DBS) check, proof of identity including copies of passports and evidence of people's right to work in the UK. Photographs of each member of staff were available in the office.

There were enough staff on duty to meet people's needs. The registered manager had carried out a review of people's needs and had increased the staffing in the mornings from two carers to three carers. People confirmed there were enough staff to provide care and support and relatives and staff also felt there were enough staff on duty to meet people's needs. Comments included, "There seem to be enough staff here", "We have enough staff in the house in the day and they are hiring" and "When I came here there were only two [carers] on the floor and we want three for activities and things. Now we are three." The registered manager said they were still recruiting for more staff in order to have enough staff to improve the activity provision and be available to go out with people more frequently. We saw the staffing rotas for September 2016 and these confirmed there were three care staff and a senior carer in the mornings now. We saw that there were catering and domestic staff employed at the service. We also saw where action was taken to cover any jobs if someone was off sick at short notice, as happened on the first day of inspection, and there were staff available to carry out all the roles required.

Good

Is the service effective?

Our findings

We asked people if they felt staff knew how to provide care and support. One person said, "They're very good at their job. They're always there when you need help and they'll listen to you."
We asked staff about training and the confirmed they received training to carry out their jobs effectively. Comments included, "I do need training because that really updates us on policies and procedures and with medication we need to know changes. They are updating us about the new things. It's quite good", "I think we have very good carers here, they are very nice. We support each other. It's important for the residents to be okay", "The seniors help you. If you need something they'll be there", "I like care home working, I want to learn" and "If I do a mistake and you tell me, I'm going to listen and follow the rules."

New staff received induction training and the booklets were kept in their records to evidence this. The registered manager said she was an assessor for the Care Certificate, the Skills for Care induction programme for care workers and said new staff would be completing this induction. We saw training records for topics including safe handling of medicines, moving and handling, first aid, food hygiene, safeguarding vulnerable adults, equality and diversity, infection control, health and safety, mental health awareness, challenging behaviour and dementia care. Care staff told us they received training and updates to keep their knowledge and skills up to date. We observed staff providing care and support for people and they demonstrated a good understanding of people's individual needs and how to support them effectively. Staff received supervision every three months and we saw some staff had also had annual appraisals. Staff confirmed they met with the registered manager and were able to discuss topics such as training and development. Staff also said they could speak with the registered manager at any time for advice and support.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood people's right to make decisions for themselves where they were able and confirmed they always asked people about their care and listened to them. Comments included, "The most important thing is to keep people safe and give them independence. It is their home, they can do what they want. It is what they want and we listen to them", "You just ask them and they tell you what they want. If a resident says 'I don't know what I want' you explain to them and show them" and "I like to involve them and speak with them. If you talk to them they'll tell you the needs they may have."

Staff were aware of the people on DoLS authorisations and what this meant in practical terms. Comments

included, "DoLS is if they don't have the choice of more important decisions in life." "DoLS is they can't leave this house without permission." Staff confirmed they would not let people leave the building unaccompanied if there was a DoLS authorisation in place. The registered manager had a good understanding and DoLS applications had been submitted for all the people living in the main building, with 11 having been authorised thus far. We saw that where there were conditions on the DoLS authorisations the registered manager had taken action to address them. For example, where someone needed more help with communication, the registered manager had found out about and contacted the relevant specialist department and was being sent information and tools to help improve communication for the person.

People told us they were happy with the meal provision at the service. Comments included, "I can get a cup of tea in the morning", "The food is alright. The chef is very good. Can't complain about the meals here, they're very good" and "Excellent quality."

People's nutritional needs were identified and action taken to provide them with the food and drink they required. We asked staff how they ensured people's nutritional and dietary needs were being met. Comments included, "We have in the kitchen a list of people who are diabetic and who need soft foods and asking is more important. They have the capacity to choose yes or no. They have options to choose what they want", "In summertime we are always giving drinks. If someone has a low weight we will call the dietician and GP", "We maintain a nutritional chart and fluid charts. If they are refusing we report this to the GP…..If they lose interest in eating it could be because they have toothache but they can't tell us" and "I know these people and if someone new is coming in I ask my manager." Staff were also clear about meeting people's dietary needs relating to any religious or cultural requirements, for example, knowing who did not eat beef due to their religion.

Staff knew about people at nutritional risk who had fortified meals to provide them with an increased calorie intake. They also told us about the food and fluid charts that were completed and we saw these in people's records. The chef had a good knowledge of the dietary needs and preferences of everyone using the service and any risks or foodstuffs to be avoided because they could interact with certain medicines people were taking. Information about any specific dietary needs were identified in the kitchen and staff were aware. The service had a set of 'sit on' weighing scales and people were weighed each month but this was increased to weekly if there were any concerns identified with their weight. Some people were prescribed liquid dietary supplements and the catering staff also supplied fortified milkshakes to assist with increasing or maintaining people's weight.

People's healthcare needs were being identified and met. We asked people if staff made sure their healthcare needs were met. One person said of the staff, "They are very medically aware." We asked healthcare professionals if staff identified when people were unwell and they confirmed they did. They also confirmed that people were referred to them promptly and appropriately for medical input. One healthcare professional said, "Staff are lovely, you couldn't fault them. Always willing to help." We asked staff what they would do if someone was unwell. Comments included, "As a carer I would first inform my senior and they'll call the GP", "We are working with them every day and we see if there is a problem and then look at the care plan and call the GP" and "In the morning we check all the service users for signs they are not feeling good and we ask them if they are okay and we notice any marks. On that basis we inform the manager and report to the GP."

We saw people's healthcare needs were identified in the care records, for example, diabetes, sensory impairment, catheter care, mental health or dementia care needs. These provided staff with clear guidance around the care people required to manage their healthcare needs. Records were maintained to identify the input people received from healthcare professionals and the treatment they received. These included input

from GP, podiatrist, community nurses, psychiatrist, optician, audiology and also attending hospital following a fall or other trauma. Where people were receiving ongoing treatment from healthcare professionals this was also recorded so there was an audit trail of the care and support people had received and also how their condition had improved.

Good

Is the service caring?

Our findings

People told us the staff cared for them well and listened to them. Comments included, "Nothing is too much for them. If you ask them they get it done. They have time to sit and talk and if they don't they make time", "They do care about people. I can have a laugh and a joke with them", "They are very thoughtful. They usually ask you, 'Is it okay, can I come into your room?'", "Staff are lovely, they are kind", "I enjoy it, I have my own room" and "They're very cooperative, they talk to me." A relative told us, "The staff here are very friendly. They seem very caring."

We saw staff caring for people in a gentle manner and providing the support and help they needed. They maintained eye contact with people and gave them the time they needed to express themselves. We asked staff what was important to them when caring for people. One member of staff said, "I think in caring it is very important to talk to them. They feel in their heart they are loved when you are talking about them and give them attention. They are alone here without their family." Another said, "We like to promote the independence of everyone. That is, they pick clothes they like and wash what they can on their body." Two staff said when caring for people they treated them as they would want their parent or grandparent to be treated, so they would be happy with the care they received.

Staff treated people with dignity and respect, offering them choices and listening to what people had to say. When we asked staff about the way they treat people, their comments included, "On the first day I present myself and asked them what they want me to call them." "We should always talk politely and ask all the time what they need. When dressing them we ask the clothes they want and we close the door and curtains." "To show respect, of course when you go into the room you have to ask if they want personal care. If they accept they have to agree with everything. Every time I knock on doors – it is their room, it would be a lack of respect not to. I have to ask their permission to open a drawer. Have to understand that's the resident's stuff. You have to take the time to explain" and "It is important to shut the door. They have to have privacy. Of course you need to ask them what they want because they can say 'no'. If they agree you can give them personal care. In here most people are helping you with their personal care."

Staff respected people's right to make choices for themselves where they were able and we heard staff offering people choices such as what food and drink they would like. We asked people if they were able to choose what they wanted to do, for example, getting up and going to bed when they wanted. Comments included, "Free range, you can do what you like really" and "They couldn't do anything better. They keep me supplied with water. When you're in your room you can do virtually what you like." Comments from staff about choice included, "I know it is very easy to go to the wardrobe to take clothes out but it is important to let them have a choice – it's their choice." "Respect and dignity come at every point of caring. You ask them what they want and give them choices." We saw people's preferences were recorded in the care plans including food likes and dislikes, waking and retiring times and their gender preference for staff providing personal care.

People's cultural and religious wishes and beliefs were identified in the care plans. A representative from the Roman Catholic Church attended the service and staff told us people also went out to attend places of

worship. Comments from staff included, "We have residents who like Indian food so we make sure they get it twice a week or if they ask. We make sure if they are religious they go to the Temple, Church, Gurdwara. If they can't eat pork we make sure we don't offer it to them. Some people like to do prayers in the morning and we make sure the room is quiet and clean. Sometimes the lady from the Catholic church comes" and "[Person] likes to hear his religious cassettes, so we make sure he hears it once a day and it is in his own language."

Menus were displayed on each table in the dining room and people were offered choices. Staff were clear about the importance of people having the meals they wanted. Comments included, "We involve family to get to know (food) likes and dislikes and give them more choices", "We have improved a lot now. If residents don't have capacity we will take two plates and ask their choice", "The chef asked all the residents this morning what they want for lunch and we ask them again at lunch when we serve in case they change their minds" and "Some people like to eat outside, so we take a tray and they have that outside." Staff were available to provide people with support at mealtimes and offered people drinks regularly throughout the day.

Requires Improvement

Is the service responsive?

Our findings

People's changing needs were identified and responded to, so they were being met. People had been assessed by the provider prior to being admitted to the service to identify their needs and ensure the service was able to meet them. The care records were comprehensive, person-centred and provided a good picture of each person, their needs and how these were to be met. The majority of care plans had been reviewed each month and reflected people's current needs. One member of staff told us, "At the moment I like that there are lots of changes. We are more precise with care records. Especially for the residents, we are trying to do everything person-centred." The frequency of care record reviews needed to be established for people with low level needs, as their care plans had not been reviewed since admission and the registered manager said this would be addressed.

Apart from for two people there was no evidence that people were being involved with the development and review of care plans and people and relatives we asked were not aware of the care plans. There was no evidence of this issue having a negative impact upon people using the service. The registered manager said this would be addressed and also explained that some people were not able to be involved and few had relatives who were appointed to act on their behalf. She said she was awaiting the appointment of Relevant Person Representatives for people on Deprivation of Liberty Safeguards (DoLS) authorisations who did not have appointees, so they would have someone to speak on their behalf.

We saw that any contact with people's family members was recorded, for example, if someone's condition had deteriorated and they had required medical care. Staff knew about ensuring people's skin was cared for and their position changed regularly, to minimise the risk of them developing pressure sores. One told us, "When doing personal care we have to make sure we use cream. They should not lie in one place and they should exercise." Staff said they had a handover meeting twice a day so staff were kept up to date with what was going on at the service. One told us, "We like to communicate – we have handover every morning and night." There was an 'inter-shift communication form' and we viewed one of these and saw this covered several aspects including identifying the staff on each shift, any events occurring during the shift, any visitors, issues relating to the building environment, activities, and any other issues/items of concern. These were completed for each shift and identified any happenings to help promote good communication between staff.

One relative told us how their family member had improved at the service. They said, "[Person] is in a much better state that she was. When [person] came here she couldn't walk and now she uses a frame or holds hands." Another visitor said, "Staff are very good. They do their utmost."
The service had a 'care delivery log' for each person to record their daily notes and those we viewed were complete and up to date and covered daily care and also monitored areas such as personal care provision, bowel and bladder monitoring and activities participated in. The care notes were completed three times in every 24 hours to cover morning, evening and night time. We asked the registered manager about daily records for everyone receiving personal care and she identified two people who were fairly independent but who did require some assistance, however although the timeframes during which staff supported them each day was recorded, the personal care they received was not. The registered manager addressed this and

confirmed they had commenced these for both people immediately following the inspection.

We saw there was a programme of activities and an activities file had been commenced to record all activities that took place. People commented about the daily exercises they were encouraged to join in with and we saw staff leading these sessions with enthusiasm. One person told us, "We do have various people that come in and do singing. We have an artist that comes in every month." "I come here (sitting room) during the day for recreation." Staff were positive about the increased activities being provided. Their comments included, "When we finish exercises [people] like to dance so I do that." "Activities also we are doing more. We do exercise in the morning. We do board games, card games, puzzles, reading the newspaper, watching TV programmes." "We are doing more activities now" and "If they feel involved in something that is an activity. We talk to them about their past and keep them involved. Music is a therapy that works for everything." One member of staff told us how they involved a person who had worked in the hospitality industry, "We take his suggestions. He feels he is involved and that he is still working."

A copy of the complaints procedure was on display in the hallway reception area so people and visitors could access it. We asked people what they would do if they had a complaint: "I'd just come in and tell them." (has not had any) "I've had no complaints. If I had a complaint I would talk to [manager]. They respond straight away. You can go and have a chat any time." A relative who had raised a concern said, "They did come back to me and I think they changed staff and now things are fine." Staff knew about the complaints procedure and that people had the right to complain if they needed to. We asked staff what they would do if someone wanted to raise a complaint. Comments included, "We will listen to them and tell the manager." "The manager's door is always open. Even if she is busy she will stop for five minutes and listen to you." A member of staff who raised some issues when they started to work at the service told us, "I can say the next day the job is done. [Manager] listens to us and takes care of your problem." There was a complaints file and all concerns, however minor were being recorded and addressed. The registered manager understood the importance of identifying any concerns and addressing them promptly. We observed that she responded immediately when someone appeared a little anxious, reassuring them and the person then looked happier and more relaxed.

Good

Is the service well-led?

Our findings

The registered manager had been in post since August 2016. She had management experience with two other services owned by the provider. People were happy with the registered manager and one said, "I brought up an issue and we got it sorted in the end. She's actually got stuff done." Staff were very positive about the registered manager and their comments included, "We have an excellent manager who manages the house", "She's a great manager, she always has the door open. She is very involved. She always has the time", "I can see the changes. [manager] is very involved and the staff like her. She does everything", "[Manager] listens. We can always talk to her straight away. In short she's good, she listens to us, she guides us. She's quite handy", "I heard we are getting new furniture and that's good for the residents", "We make sure what you (CQC) are expecting from us we do as soon as possible" and "The new management are fantastic, I'm really happy. They are giving me everything I need."

Meetings for people using the service took place every three months. We saw that issues including the need to drink more in hot weather, activities and new cutlery had been discussed at the last meeting. People said they had also brought up about the menus and there had been improvements made as a result. Staff meetings also took place every three months and the minutes were comprehensive, covering a wide variety of topics such as training, diet and hydration, safeguarding, Deprivation of Liberties Safeguards, complaints, key workers and activities. One area of concern that had been identified by the local authority during their monitoring visits was poor record keeping. This had improved significantly at their last visit. The registered manager had accessed Skills for Care training booklets which explained about using simple language and writing clearly and descriptively, to help staff with written English.

The registered manager carried out observation sessions with staff when undertaking their work, for example, assisting someone with their meal. She explained she did this as part of staff supervision and would then meet with the member of staff to discuss her findings and if necessary agree any action to help the staff member improve their practice. There were also staff supervision questionnaires on different topics such as food and hygiene, moving and handling and a general competency test. For staff that had been with the provider over a year we saw appraisals had been carried out. The registered manager said these all fed into the supervision process for monitoring staff progress and identifying areas for development. The registered manager was appointing 'champions' among the staff for specific areas. For example, one member of staff had done training in nutrition and related topics and was the nutrition champion and would pay particular attention to anyone identified as at nutritional risk. Other champions were for pressure area care and activities.

We looked at the monitoring of areas of the service. The care delivery logs covered a period of two weeks and in addition to care information they also contained environmental checks of each person's room and belongings to ensure they were in good order. The registered manager then audited the logs when complete and used the information to help identify any areas for improvement. The registered manager carried out monthly audits of medicines and said she would do a full audit of the medicines and increase the frequency of checks to ensure any shortfalls were addressed. The registered manager told us she had identified areas for refurbishment with the provider and they had agreed to new carpets and new bedroom furniture which

was due at the end of September 2016. We requested the business development plan for the service and received this for 2016-2017, which included refurbishment information and other areas of development such as increased training opportunities for staff. It also identified areas for improvement where shortfalls had been identified by the local authority, for example, record keeping, staff training and improving communication with the local authority and other stakeholders to effectively safeguard the care and welfare of people using the service.

The registered manager was involved with developing new monitoring tools for use in the service and demonstrated a good understanding of what was required to monitor services effectively. A quality assurance review was carried out in April 2016 and surveys had been sent out to relatives and stakeholders. The outcome of the surveys was very positive and the service had a 'Happiness rating' of 99% and concluded, "Service user satisfaction in the service is high."

The registered manager said she kept up to date with good practice by accessing articles of interest on the internet and gave examples of pet therapy, dementia care and activities provision. She said she was registered with the National Institute for Clinical Excellence and the Medicines and Healthcare products Regulatory Agency and received newsletters and safety information relevant to her role. The registered manager had also attended provider forum meetings at the local authority and found these helpful to get information about the area and ideas for outings in the borough. She also undertook training and updates to keep her knowledge and skills up to date and was a Care Certificate assessor, a moving and handling trainer and had also undertaken training in pressure ulcers and end of life care in recent months. She was very responsive during the inspection and demonstrated the knowledge and skills to address shortfalls promptly.

Policies and procedures were available and were in the process of being reviewed by the provider. These were comprehensive and covered each aspect of the service and people's care and support. With the exception of safeguarding events that had been raised by the local authority, notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required. We discussed with the registered manager notifications for any safeguarding incidents that might occur and she was clear on this. The provider also confirmed they would ensure all relevant notifications were submitted in future.