

Rosecare (Brookholme) LLP

Brookholme 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?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

The inspection took place on 24 and 26 November 2015 and was unannounced.

We had previously carried out an inspection on 6 February 2014 when we found the service had breached the regulations relating to cleanliness and infection control, and to the management of medicines. On this inspection we found the provider had taken action in relation to this.

Brookholme is a 40 bed residential home in a suburb of Chesterfield. The service provides accommodation and personal care for up to 40 older people. At the time of our inspection there were 40 people living there. A number of people at the home were living with a diagnosis of dementia.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission 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 safely cared for. Staff were trained and knew how to recognise people at risk of harm. They knew how to report concerns.

There were safe recruitment procedures in place. The provider carried out checks to ensure that suitable people were recruited. Staff undertook an induction

Summary of findings

before being assessed as competent to provide care and had a probationary period. The provider had policies and procedures in place if staff did not meet the standards expected of them.

People and their relatives felt there were not enough staff employed to provide care. Staff had mixed views on this, and we saw there were times when there was a risk of people not receiving support to take part in hobbies and activities as they wished.

Medicines were stored, administered and disposed of safely and in accordance with professional guidance. Staff received training and ongoing monitoring of their skills and knowledge.

People were cared for in an environment that was clean and well managed to prevent the risk of infections. Staff were trained in and understood their roles and responsibilities in the prevention of infection.

People were supported by staff who received training and supervision to ensure that they had the skills the provider felt necessary for their role. Staff demonstrated good knowledge about people's care needs and preferences, but this was not always reflected in the written care plans.

People's dietary needs were met. They had regular drinks and snacks, and diets to meet their health needs. Staff provided alternative meal choices and people were involved in discussions about the menu.

Staff obtained consent from people before providing support. Where people were not able to give their consent, not all staff understood the requirements of the Mental Capacity Act.

Staff knew people well and could tell us how to provide care that was person centred. However, people were not always involved in planning and reviewing their care, and aspects of care did not uphold people's dignity.

The provider sought feedback about the service from people, their relatives, visitors and staff. There were a variety of ways people could make their views known. However, there was no clear way of supporting people to make their views known or make complaints if they had communication difficulties or other impairments that reduced the likelihood of them speaking up.

There were systems in place to monitor and review all aspects of the service. However, these did not always identify gaps in people's care planning. This meant identifying areas of good practice and areas for improvement was inconsistent.

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?

The service was not consistently safe.

The service did not always have sufficient staff available to meet people's psychological and emotional needs.

People received their medicines as prescribed. Medicines were stored and disposed of safely and in accordance with guidance.

People were protected from the risk of infections by staff who understood their roles and responsibilities in infection prevention and control.

Requires improvement



Is the service effective?

The service was not consistently effective.

People's care plans did not always contain sufficient information to enable staff to support them effectively.

People were provided with a choice of suitable food and drinks that met their dietary needs.

Understanding and application of the Mental Capacity Act was variable. Staff were aware of their responsibilities with regards to the Deprivation of Liberty Safeguards to that people's care was least restrictive and lawful.

Requires improvement



Is the service caring?

The service was not consistently caring.

People were not always supported in their personal care in a manner that upheld their dignity.

People and their relatives spoke positively about the staff team and felt they were kind and caring.

People were not always involved in making decisions about their own care.

Requires improvement



Is the service responsive?

The service was not consistently responsive.

People experienced varying levels of support to maintain interests and hobbies.

The provider had systems in place to listen to views and respond to concerns and suggestions for improvement.

People and their relatives were involved in planning their care, but documentation did not always reflect what people's views or wishes were.

Requires improvement



Summary of findings

Is the service well-led?

The service was not consistently well-led.

The provider's quality management system did not always highlight areas of concern in a timely manner, so that improvements could be made.

People, their relatives and staff felt able to share their views about how the service was run. They also felt that the provider and registered manager were approachable and responsive.

Requires improvement



Brookholme Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 24 and 26 November 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience on this inspection has experience of caring for an older person using both residential care services and community health and social care services.

Before our inspection we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. We spoke with the local authority commissioning team and

Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. No concerns were raised by them about the care and support people received.

We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

During the inspection we spoke with thirteen people who used the service and eight relatives. We also spoke with the owner of the service (the provider), registered manager, eight staff and two visiting health and social care professionals. We looked at a range of records related to how the service was managed. These included five people's care records, three staff recruitment and training files, and the provider's quality auditing system.

Not all of the people living at the service were able to fully express their views about their care. We used the Short Observational Framework for Inspection (SOFI) to capture the experiences of people who may not be able to communicate their views.

Is the service safe?

Our findings

On our previous inspection on 6 February 2014 we had found there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2010. People were not always protected against the risks associated with the unsafe use and management of medicines. On this inspection we found that the provider had made improvements in this area.

Medicines were managed, stored, administered and disposed of in accordance with professional guidance. Staff who had responsibility for medicines had received training, and had ongoing observation of their skills to ensure that they were competent to manage medicines safely. One staff member said that the medicine management had improved since the last inspection and said they had a, “Very good system.”

We saw that people were offered their medicines by staff who took time to ask people for their consent, and explained what different medicines were for. The provider had a protocol in place for people who regularly declined their prescribed medicine. We saw one person’s plan addressed the issue of consent, and detailed what steps staff should take in the event of the person repeatedly refusing medicines. Another person managed their own medicines. We saw this person had moved to the home in the previous 24 hours, and had written guidance in place for staff to remind them that the person managed medicines themselves. The person had capacity to consent to doing this, and had secure storage in their bedroom for medicines. The provider had worked with the local GP surgery to reduce the risk of prescription errors and to ensure that people received prescriptions on time.

On our previous inspection on 6 February 2014 we had found there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010. The provider’s systems to protect people against the risk of acquiring infections were not wholly effective and they had not maintained appropriate standards of cleanliness and hygiene. On this inspection we found that the provider had made improvements in this area.

People were protected from the risk of infection. Staff told us they had recently had training in infection prevention and control (IPC), and were confident this was sufficient to enable them to reduce risk of infection in the service. Staff

we spoke with understood what their responsibilities were to ensure that the environment was kept clean, and we saw staff were using appropriate personal protective equipment when this was necessary. Staff felt there were enough domestic and laundry support staff on to ensure that the service was cleaned properly, with two domestic staff available seven days a week, and one laundry staff member during weekdays. The staffing rotas we saw supported this. The provider had identified a member of staff who was responsible for leading on IPC, and staff knew who this was.

The provider had a detailed daily, weekly and monthly cleaning schedule, and we saw daily cleaning tasks being carried out. The IPC lead staff member was responsible for ensuring this was done and we saw this was being carried out as planned. The provider had clear accessible policies and procedures for cleaning and minimising the risk of infection. Staff understood what their duties and responsibilities were. We saw that a suspected outbreak of infection had been managed in an effective and appropriate way. This demonstrated the provider was taking action to ensure that the service was free from the risk of infection.

The service did not always have sufficient staff to meet people’s needs. People did not think that there were enough staff to support them in a timely manner. One person commented, “The main problem is at night. If I press my buzzer sometimes it takes ages for a carer to come, by which time it’s usually too late.” Another person said, “Sometimes the carers are really busy and if you ask for something, they say they’ll see to it, but then they have to see to someone else and they forget.”

A relative said they did not think there were enough staff to support people, stating, “The weekends are worst, particularly Sundays. There aren’t many staff around so you have to hunt for someone to help.” Another relative said, “The carers are always flying around and I don’t like to ask them anything because they’ve got their hands full constantly.”

Staff had mixed views about whether there were enough staff to be able to meet people’s needs promptly. One staff member said there was an, “Ongoing debate about whether there are enough hands-on staff. Carers have a lot of pressure and try their best to ensure everyone gets what they need.”

Is the service safe?

The provider used a dependency tool to help establish how many staff were needed, and this was reviewed weekly, or more frequently, if people's needs changed quickly. The registered manager used the dependency tool to work out the staff rota, and we saw this was being reviewed regularly. The dependency tool and rota showed us there were enough staff to meet the assessed needs of people. We spoke with the registered manager about people and relatives' views of staffing levels. They agreed they would investigate whether or not there were enough staff, or whether this was an issue of how staff were deployed. The findings of our inspection indicated although people's key physical needs were, overall, being met, there was a risk that their psychological and emotional needs were not.

People we spoke with told us they felt safe living at the home. One person said, "I think I'm safer here than at home." People felt confident to raise concerns about their safety with staff and felt they would be taken seriously. Relatives felt people were safe at the home and protected from the risk of harm.

People and their relatives told us they felt supported to be safe. One relative told us after their family member had a fall staff put additional measures in place to reduce the risk of harm from falls. For example, the person had chair and mattress sensors to alert staff when they got up. This meant staff could go and offer the person support quickly to reduce the risk of falls.

Staff worked with the physiotherapist from the local GP surgery to regularly review people who were at risk of falls, and staff received additional support to promote people's mobility. This showed us people were encouraged to remain as mobile as possible, and had access to a specialist service to enable them to do so safely.

The provider had safeguarding procedures in place that were understood by staff we spoke with. Staff knew how to recognise the risk of abuse and what steps to take to report

concerns within the service and also to the Local Authority. Staff felt confident to raise concerns about care with the provider and with CQC if this was needed. This demonstrated people were cared for by staff who knew how to protect them from the risk of harm.

Records showed us that staff clearly identified risks to people's well-being, and reviewed these regularly. For example, one person was at risk of pressure sores. Their risk assessment was up to date and showed what staff needed to do to reduce the risk. We checked that the person was supported to change position regularly and we saw this was happening. This showed us risks were identified, monitored and reviewed regularly, and staff were able to take steps to prevent people from the risk of harm.

The provider had ensured that there was sufficient information available about people's essential needs in the event of an emergency. This was easily available to staff and emergency services if needed, and included information about the amount of support people needed to move out of the building.

The provider had processes in place to ensure that potential staff had checks carried out to ensure that they were suitable to work with people who lived at the service. The records we checked showed staff only started work at the service when satisfactory references and checks were received, including a disclosure and barring check (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and to prevent unsuitable people from working with children and vulnerable adults. This helped to ensure people were protected against the risk of being cared for by unsuitable staff.

Is the service effective?

Our findings

People felt staff had the skills to meet their needs, and relatives expressed the same view. One person described their care as, “Good,” and another person said, “You can’t knock it.” One relative said “I think the carers are well trained. I just don’t think they have the time to do their jobs as well as they’d like.” Another relative said, “Staff do know [person] well and notice if they are not themselves and tell me.”

Staff we spoke with demonstrated good knowledge about people’s care needs and felt they received enough training to have the skills and knowledge to support people effectively. Staff also felt they received supervision regularly and this helped them improve their care skills. One staff member said supervision and training looked at whether they had the values and attitudes that the provider expected from staff. New staff undertook a period of induction and essential training, and all care staff undertook nationally recognised qualifications in health and social care skills. The records we looked at showed staff undertook training the provider felt necessary. Staff also had regular assessment of their skills to enable them to meet people’s needs safely.

However, within some people’s care plans, key information to enable staff to support them properly was not included. For example, one person’s care plan indicated they behaved in ways that others could find challenging, but there was no details of behaviours and no guidance for staff on how to support the person. Another person’s care plans did not contain any information about their non-verbal communication that staff should be aware of and monitor. The registered manager acknowledged there was not enough detail in people’s care plans to enable all staff to support people well. This put people at risk of their health and social care needs and preferences not being met.

The provider had recently allocated several places for people who needed up to six week of care whilst recovering from orthopaedic surgery. Staff called this the non-weight bearing pathway (NWBP). This was an arrangement with Chesterfield Royal Hospital NHS Foundation Trust. Staff were knowledgeable about the care needs of people receiving the NWBP service, and what additional support people needed. For example, staff spoke with us about one person who needed additional support and equipment to

move safely and demonstrated that they understood how to provide care. We saw that this person’s care plans contained detailed information on what support they needed and that the necessary equipment was available. This assured us people would receive the support they needed whilst recovering from orthopaedic surgery.

People told us that staff sought their consent and explained what they were doing when they provided care. 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).

Staff had received training on the MCA and DoLS but their understanding was variable in relation to this. For example, staff told us that the provider had a policy on restraint, but they did not use restraint on anyone. When we explored this with staff, they did not know that the use of bedrails, sedating medicines or the use of seat sensors might contribute towards being a restraint for people. Staff knew which people had a DoLS authorisation and what this meant. The registered manager had identified people who needed to be assessed for DoLS and made appropriate referrals to the local authority.

However, people’s care plans did not consistently record what decisions people could and could not consent to. Two people’s consent to care and treatment forms were signed on their behalf by others. We confirmed with staff that the people signing the forms did not have the legal authority to consent on their behalf. One person’s records contained contradictory information about whether their relative had a Lasting Power of Attorney (LPA) for health and welfare or for property and financial affairs. There was no copy of the LPA to enable staff to check what decisions this authorised the relative to make. We spoke with the registered manager about this, and they confirmed that they did have a copy of the LPA. They agreed that they

Is the service effective?

would clarify the type of LPA and ensure that this was recorded appropriately. This showed us that people were not always protected from the risk of decisions being made about them unlawfully.

People's care plans did not always have sufficient information about food preferences or specific dietary needs. One person's care plan stated that staff needed to support them to, "remain a healthy weight." There was no information about what would be a healthy weight for the person, how staff would support the person to maintain a healthy weight, and what staff should do if the person's healthy weight could not be maintained. We asked the registered manager if staff knew what the person's weight should be, and were told that they did not. Evidence showed staff were regularly monitoring people's weight, and staff said they would contact the GP if concerned about a person's weight loss or gain.

People were supported to have a varied diet and their preferences were respected. People told us that they liked the food and that they had choices offered to them, including alternative meals if they did not want what was on the day's menu. People's views on the food ranged from, "very good" and, "mainly good" to "mostly satisfactory." People told us and we saw that they were regularly offered drinks and snacks throughout the day, including fresh fruit. People told us that they felt able to ask for food and drinks whenever they wanted, but one person commented that staff did not always remember to respond, "I like a glass of milk at night and I always ask a carer if I can have one. They always say yes, but they go away, and they must forget because often times I don't get one." People told us they were involved in discussions about menu planning and we saw evidence to support this.

Staff knew people's food and drink preferences, and we saw they checked with people that they had prepared the right drink before they served it to them. Staff knew how to support people with specific dietary needs. For example, one staff member said they had identified using smaller plates for three people meant that they ate more, and for other people, adapted cutlery and drinking cups enabled them to eat more independently. Staff had detailed information about people's dietary requirements and preferences. They had surveyed people recently to find out what they thought about the menu and whether people had any suggestions for improvement. Some people needed full support with their meals and care workers were

allocated individually to these people. Clothes protection was offered to people in a discreet manner. Care workers spoke sensitively with the people they were supporting, and gently woke people if they were asleep during the day to ensure that they had enough to eat and drink.

The provider had arranged mealtimes to take place over two sittings to enable everyone to receive enough support to eat and drink. One relative told us the lunch time experience for the first sitting was inconsistent, saying it was, "Sometimes good and sometimes not so good." They also told us the first sitting lunch time could feel disorganised, stating, "It really depends which carers are on duty. Some carers are better than others at organising the lunch time." We saw that everyone who needed support to eat and drink received this in a caring and dignified way. This demonstrated people were supported to have sufficient food and drink.

People told us staff would call a doctor if they were unwell. Relatives said staff kept them informed about people's healthcare needs, for example, if the person had been seen by the GP. One relative told us their family member had frequent falls and staff would telephone them to let them know what had happened, and what action had been taken.

We saw that people were supported to access the local GP service on a regular basis and had an annual GP review of their health and medicines. People's records also showed us they were supported to have regular access to external health and social care professionals, such as community nurses, social workers, chiropodists and opticians.

The home was decorated in a way that could be confusing for people with dementia. We spoke to two staff members who confirmed all of the bedrooms and most of the communal areas were painted cream. The bathrooms & bathroom fittings were white, with no other colour that would assist people to identify where essential facilities were. There was little colour differentiation in key areas. For example, the colour of the doors, walls and doorframes were a similar tone. There were few adaptations made to aid orientation for people with a visual impairment or dementia, for example, clear signs for different areas of the home. There were no sensory or tactile displays, or reminiscence areas which might be beneficial for people with visual impairments or dementia. We spoke with the registered manager about looking at guidance on best practice to promote an environment that was more

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appropriate for different health conditions, which they said they would look at. This demonstrated the environment was not always tailored to meet people's individual needs and preferences.

Is the service caring?

Our findings

People's privacy and dignity was not always respected. We saw several people using a downstairs toilet where the door opened into the hallway. One person struggled to close the door, and although staff went to support them, the staff member left and returned to the toilet twice without closing the door properly or knocking. Another person was supported by two staff to use the toilet. Staff used a privacy screen to enable the person to get their wheelchair into the toilet. However, they did not then close the door. We saw staff go into the toilet to support a third person without knocking or seeking permission. We spoke with the registered manager about this, and they said this was an issue which had been raised with staff before. The service was taking part in the local authority's Dignity Award campaign. Derbyshire County Council states, "A key test is if you're treating people with the same dignity and respect as you would want for yourself or your family." The registered manager assured us that they would speak with staff about closing toilet doors when supporting people. This showed us that people's dignity and privacy was not always respected. Staff knowledge and understanding about the principles of dignity in care was not embedded into practice.

People said staff were kind, caring and respectful. One person said, "The carers are very kind and patient with me and other people too." Another person commented, "I think the carers are kind people and they do a very hard job." However, people told us that they wished staff had more time to talk with them beyond conversations about care needs. For example, one person said, "It's so nice to chat to you – it makes a real change because most of the time it's very boring sitting around all day."

Relatives also felt that staff have developed good caring relationships with people. Relatives were encouraged to visit regularly, and told us staff were always polite, helpful and respectful towards everyone. One visitor told us they

were always welcomed and offered meals so that they could spend more time with the person they visited. A visiting social care professional described staff as, "Kind and caring with people," and said staff had been very reassuring and patient with one person to help them settle when they first moved to the service.

Staff interacted with people with patience and care. They spoke kindly and respectfully with people, explaining what support they were offering and checking that people were happy with their care. People were supported by staff who were kind and demonstrated that they cared about their well-being.

People had access to advocacy services, and there was information about local services in the main entrance of the service. One staff member was knowledgeable about how advocacy services could support people and how they would help people to access them. One person had received support from an independent mental capacity advocate (IMCA) for a recent review of their care.

People told us the care workers helped promote their independence. One person said, "I can do most things for myself. I just need a bit of help putting my support stockings on. So the carers come into my room when I'm ready for that." Another person said, "I'm lucky because I can walk without any help, so I can go up to my room when I want." One person had an adapted armchair which enabled them to be able to get out of the chair independently, and they told us that they liked being able to do this.

We saw that people's care records were stored securely, and staff demonstrated they understood how to keep people's personal information confidential. For example, staff talking with visiting healthcare professionals ensured that they did this in a way where others would not overhear. This showed us people's right to confidentiality was respected.

Is the service responsive?

Our findings

Many people we spoke with told us about their previous work, hobbies and interests. However, almost all the people we spoke with felt they were not always supported to maintain their interests. One person said, “I’m lucky because I can go to my room if I like and I’ve got some crossword books that my family give me, so I’ve got something to keep my brain going.” A second person said, “I like watching westerns, but I’ve never seen one here,” and a third commented, “I like the Sound of Music and I do sing along to that sometimes. I’d like to sing more though.” A relative said, “I don’t think there’s enough to do for people here. When I come, there’s never anything going on and the carers are always busy.”

The provider was in the process of recruiting an activities coordinator. Records showed that the previous coordinator had developed activities that were varied. They kept detailed records of people’s likes and preferences and noted how people responded to different activities. However, this information was not recorded in the main care records. Most staff did not access the activity records so information about people’s preferences was not available to all staff.

The provider had appointed an external activities coordinator to ensure that people were still offered activities for three sessions each week, in the absence of a permanent staff member. On the first day of our inspection there was a session led by the external coordinator involving exercise, music and social interaction. Fourteen people had chosen to join in this activity, and other people said this activity did not appeal to them. However, at other times of the day, when the activities coordinator was not present, people in the communal areas of the home received a varying amount of support from staff to engage in conversations or interests. We observed some, but not all staff took opportunities to engage people in interesting conversations to stimulate them. We observed some people spent the morning passively watching other people and falling asleep. People experienced varying levels of support to maintain interests and hobbies.

We also noted that, in the two lounge areas, each lounge had two televisions playing different channels. One person told us that they were seated so that they could hear two televisions but see neither of them. When asked if they would prefer to sit somewhere else, they said, “Well I

suppose that would be better, but I don’t like to make a fuss.” Another person said, “There’s two televisions on in this room. I can’t see them, but I can hear them and they’re on different channels. It’s really annoying.” A third person said, “I don’t know why they have these TVs on. No-one’s watching them and I don’t even know what the programmes are.” We spoke with three people in one lounge and established that they did not like this situation, but did not want to tell staff because they appeared busy. Staff told us that the televisions were usually on, and they did try to find a channel that everyone was happy to watch. We spoke with the registered manager about this, and raised a concern that some people were not happy with the situation but did not feel able to tell staff. They assured us that they would speak with people and address this issue. This demonstrated people’s individual needs and preferences were not always identified or responded to.

People could not recall being involved in reviews or decisions about their care, however everyone we spoke with was happy with this and did not want any more information on their care plans. Relatives were involved in people’s care planning where people consented to this, or where this was in people’s best interests. One relative told us they were involved in care plan reviews for their family member, and said, “I find the reviews useful to tweak some of the care.”

Staff told us they tried to support people as much as possible to be involved in making decisions about their care. One staff member said, “We have to make time to talk to people about what their preferences are.” However, the way in which people’s care plans and reviews were documented did not demonstrate how people were involved in making their own decisions, or expressing their views and preferences. For example, one person’s care plan about personal care briefly outlined what the person’s needs were, what the aims of care were and how this would be achieved. The plan did not say whether the person had any views about their own care needs and how they would prefer to be supported.

People and their relatives felt able to raise concerns about care, and knew how to do this. However, on the first day of our inspection, we saw people and relatives raised concerns about being cold which were not responded to in a timely way. People told staff that they were cold in the conservatory but the situation was not remedied. One relative said “This conservatory is a real problem. It’s

Is the service responsive?

boiling hot in summer and freezing in winter and you can see that people have to sit in here because there's no other space." Staff acknowledged it was cold, and although they supported people to get extra clothing or blankets when people asked, they did not address the issue of temperature in the home. We spoke with the registered manager about this, and noted that at the end of the first day of our inspection, the temperature had been increased in the home.

Three relatives commented on their experience of raising concerns. One relative said, "The issues have been mainly resolved, but it feels like hard work because we have to keep raising things when actually they should be sorted without having to ask." Another relative said, "The care here is ok, so long as you've got family who can keep an eye and monitor what's happening" and a third visitor observed that, "It's difficult when there's no family to chase things up."

There was a comments and suggestions box in the reception area and the provider's complaints policy was clearly displayed in communal areas of the home. The registered manager had a monthly 'open-door surgery', as well as being available throughout the week. There were monthly meetings for people to make suggestions or raise concerns about the service. We saw that the provider took action on these, and people were informed about any changes or improvements to the service. For example, people said they wanted more fresh fruit available throughout the day, and we saw that this had happened. People had also said they wanted to have more activities in the garden, and the records showed that this was offered to people. When we looked at the complaints records, we saw that the provider recorded what the complaint was, what action was taken and what the outcome was. This meant the provider had a process in place to listen to complaints and take action.

Is the service well-led?

Our findings

The registered manager undertook weekly and monthly checks to ensure that the service was providing safe and effective care. These checks included the analysis of accident, incident and medicine errors, and infection prevention and control measures. Checks looked at showed what issues were noted and what action was taken to minimise risks. For example, the audit for October 2015 identified that there were some gaps in staff signing for medications, and that relevant staff had been spoken to about this to remind them that all medicines must be signed for. However, the audit system had not picked up that people's care plans lacked essential information to enable staff to deliver person centred care. There was also no evidence that training and staff supervision had addressed the issue of staff not consistently supporting people with dignity and respect.

The provider sought regular feedback from people, relatives and staff about the quality of the service. We saw an action plan which detailed issues raised and what action was planned or had been taken to improve the service. For example, people and relatives had suggested that carpets be replaced in communal areas. The action plan noted that this was a work in progress and we saw areas where the carpets had been replaced. Relatives had also said that they did not know about the provider's complaints procedure, so action was taken to ensure that information was made available throughout the service.

People and their relatives knew who the registered manager was and told us they felt the home was well run. Relatives said they felt the registered manager was approachable if they needed to make any suggestions or raise concerns about the way the service was run. One relative said, "Since [registered manager] took over it's been well organised and well run. [Registered manager] does a really good job."

People and their relatives had mixed views about being consulted about the development of the service. Most people we spoke with could not say if they were consulted, but we saw there were regular meetings where people living at the service were encouraged to share their views.

The provider did not hold regular relatives' meetings, but sought feedback in other ways, for example, using questionnaires and having a monthly "drop-in" session with the registered manager. Relatives told us they preferred to speak directly to the manager about specific issues.

Staff were positive about the provider and the registered manager. They told us that they felt supported and listened to if they raised concerns or had suggestions to improve care. Staff had regular supervision and staff meetings with the registered manager where they felt able to discuss concerns about the service and make suggestions. One staff member told us they had a, "Really supportive management team." Another member of staff described the provider and registered manager as, "Very approachable." We saw that the registered manager had an 'open door' policy and throughout our inspection, people, relatives, and staff came to speak with them frequently.

The registered manager understood their role and responsibilities in ensuring that the service provided care that met the regulatory standards. They consistently notified CQC of any significant events that affected people or the service.

The registered manager met every three months with the local GP surgery to discuss ways in which staff and medical services could work together to support people more effectively. As a result of this, changes had been made to ensure that access to medical care was timely and appropriate. For example, there were discussions recorded about what action staff and the district nurses took to ensure better pressure area care. This showed us that the provider was able to work with local health services to ensure people's medical needs were met more effectively.

The registered manager and the deputy manager confirmed that they kept their skills and knowledge updated through a range of organisations, including The Registered Nursing Homes Association, Skills for Care and the Social Care Institute for Excellence.