HICA

Overton House - Care Home

Inspection report

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Date of inspection visit: 24 September 2015
Date of publication: 29/01/2016

Ratings

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

Overall summary

We carried out this inspection on 24 September 2015 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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This was an unannounced inspection which meant that the staff and registered provider did not know that we would be visiting.

At the last inspection on 2 June 2014 we found Overton House Care Home was meeting the requirements of the regulations reviewed.

Overton House is in Cottingham, in the East Riding of Yorkshire and is registered to provide personal care and accommodation to 40 older people who may also have a memory impairment. Accommodation is all on the ground floor and in single occupancy bedrooms.

The provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

the service. Like 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 understood the Deprivation of Liberty Safeguards (DoLS); however, we found that Mental Capacity Act (2005) guidelines had not been fully followed. This was a breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

We found that people were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

We saw that there were sufficient numbers of staff on duty and people's needs were being met. We found that effective recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

The home had a system in place for ordering, administering and disposing of medicines and this helped to ensure that people received their medication as prescribed.

We found that the homes premises and equipment were clean and properly maintained. The registered manager was aware of guidance in respect of providing a dementia friendly environment and progress had been made towards achieving this.

We saw that staff completed an induction process and that they had received a wide range of training, which covered courses the home deemed mandatory such as safeguarding, moving and handling and infection control and also home specific training such as dementia awareness.

Staff told us that they felt well supported by the registered manager and could approach them if needed. They told us that they received formal supervision, but could also approach the registered manager with any concerns at any time.

We found that people's nutritional needs were met. We also saw that the lunchtime experience for people living in the home was a relaxed and enjoyable experience.

People were supported to maintain good health and had access to healthcare professionals and services. People were supported and encouraged to have regular health checks and were accompanied by staff or relatives to hospital appointments.

We observed good interactions between people who used the service and the care workers throughout the inspection. We saw that people were treated with respect and that they were supported to make choices about how their care was provided.

People's needs were assessed and care and support was planned and delivered in line with their individual care needs. The care plans contained detailed information about how each person should be supported, although more detail was required in plans relating to managing behaviours that challenge.

The service employed an activity coordinator and offered a variety of different activities for people to be involved in. People were also supported to go out of the home on day trips or to access facilities in the local community.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided.

We found that the provider had audits in place to check that the systems at the home were being followed and that people were receiving appropriate care and support.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff displayed a good understanding of the different types of abuse and had received training in how to recognise and respond to signs of abuse to keep people safe from harm.

Risk assessments were in place and were reviewed regularly which meant they reflected the needs of people living in the home.

The home had a robust system in place for ordering, administering and disposing of medicines.

Is the service effective?

Requires improvement

The service was not always effective.

The homes manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS). However, we found that Mental Capacity Act (2005) guidelines were not being fully followed.

Staff had received an induction and training in key topics that enabled them to effectively carry out their role.

We found that the lunchtime experience for people in the home was a relaxed and enjoyable experience and that people were supported to eat and drink enough.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people.

People who used the service received additional care and treatment from healthcare professionals in the community.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care workers throughout the inspection.

People were treated with respect and staff were knowledgeable about people's support needs.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were produced, which identified how to meet each person's needs.

We saw people were encouraged and supported to take part in activities.

Summary of findings

There was a complaints procedure in place and people were informed about how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Good

The service was well led.

The service had effective systems in place to monitor and improve the quality of the service.

Staff and people who visited the service told us they found the registered manager to be supportive and felt able to approach them if they needed to.

There were sufficient opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

Overton House - 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.

This inspection was carried out on 24 September 2015 and was unannounced.

The inspection team consisted of two Adult Social Care (ACS) inspectors and one inspection manager.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commission a service from the home. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they may have had with the home.

The provider was not asked to submit a Provider Information Return (PIR) prior to the inspection, as this was not a planned inspection. 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.

During the inspection we spoke with two visiting relatives, four members of staff, and the registered manager. We spent time observing the interaction between people who lived at the home, relatives and staff. 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 looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for four people, handover records, the accident book, supervision and training records of three members of staff, staff rotas, and quality assurance audits and action plans.

Good

Is the service safe?

Our findings

The service had policies and procedures in place to guide staff in safeguarding people from abuse. The registered manager explained how they used the local authorities safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegations of abuse.

The staff we spoke with told us they had received safeguarding training and could offer insight in to the types of abuse that could occur in a care setting. All of the staff told us they would initially speak with the senior carer on duty regarding any concerns and would escalate the concern appropriately if they were dissatisfied with the response they received from within the provider organisation. Staff told us they were also aware of the whistleblowing policy and that they could contact either the local authority or the Care Quality Commission (CQC) with any concerns. None of the staff we spoke with expressed any concern with regards to the standard of care delivered to people living in the home.

We saw that safeguarding concerns were recorded, audited weekly and submitted to both the local safeguarding team and also the CQC as part of their statutory duty to report these types of incidents. This showed that the registered manager took the responsibility of reporting these incidents seriously.

We saw there were systems in place to ensure that risks were minimised. Care plans contained risk assessments that were individual to each person's specific needs. This included assessed risk for falls, pressure care, mobility, nutritional status, sensory impairment, mobility, breathing and distressed behaviour. We saw the manager monitored and analysed all accidents and incidents and reported these on a monthly basis to the registered provider for further analysis. This was a measure to help ensure that any learning was identified and appropriate adjustments were made to minimise the risk of the accidents or incidents occurring again.

We saw that the provider monitored the maintenance of the building with support from the estates team to ensure that the premises and all equipment was checked in line with current guidelines. We viewed documentation and certificates that showed us that the relevant checks in relation to fire safety, utilities, hoists, wheelchairs and bath temperatures had been completed within the stipulated timeframes. This ensured they were safe and in good working order. The home had a current fire safety policy and procedure, which clearly outlined what action, would be taken in the event of a fire. A fire safety risk assessment had been carried out so that the risk of fire was reduced as far as possible. We saw that the home completed regular fire drills which helped prepare staff to respond appropriately in the event of fire. The registered manager had also developed up to date personal emergency evacuation plans (PEEP) for each person they cared for. These are documents which advise of the support people need in the event of an evacuation taking place.

The registered manager told us that staffing levels were assessed and monitored based on the needs of the people who used the service. On the day of the inspection we were told two people required significant levels of additional support to ensure that that their needs were met, whilst also protecting the welfare of other people in the home. The registered manager told us that they had a degree of autonomy with regards to staffing levels and were able to bring in additional staff quickly to ensure that people were safe and their needs were met by the service. On the day of inspection we saw that there was the registered manager, deputy manager, a senior care worker, five care workers and two additional care workers who were providing one to one care. We found that there were sufficient staff on duty to meet the needs of the people living in the home.

We looked at the recruitment records of three members of staff and saw evidence that the registered provider had taken steps to protect people from staff who may not be fit and safe to support them. A Disclosure and Barring Service (DBS) check had been completed before they started work in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children or vulnerable adults. This helps employers make safer recruitment decisions and also prevents unsuitable people from working with children and vulnerable adults. Two of the files we viewed showed all relevant police checks and references had been obtained prior to employment and were satisfactory.

The registered manager told us that only team leaders and senior care workers administered medication and we saw they had undertaken appropriate training. We observed the administration of medication and saw that this was carried out safely; the staff member did not sign medication

administration record (MAR) charts until they had seen people take their medication apart from one occasion when they did not wait to check that the person had actually swallowed their tablet. People were provided with a drink of water to assist them with swallowing.

The staff member told us that they gave people their medication when they got up and / or came into the dining room for breakfast. This meant that they did not work through the MAR charts in alphabetic order. We asked the staff member how they ensured they had administered medication to everyone who needed it. They showed us a checklist that they used on each occasion they administered medication; this reduced the risk of errors occurring. The checklist was also used to make any notes about a person's medication needs so they could be recorded in care plans or handover notes.

There was an audit trail that ensured the medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Discussion with the staff member administering medication indicated they had a clear understanding of the need to leave suitable gaps between administration times. For example, if someone had their morning medication at a later time, the remaining medication for the day would also have been given at a later time.

Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where all of the tablets to be administered at one time are held in the same compartment. The blister packs were colour coded to signify the time of day they were to be administered.

Blister packs were stored in the medication room and transferred to the trolley at the time they were to be administered. The medication trolley was locked and fastened to the wall in the medication room when not in use. The medication fridge was also stored in the medication room and we saw that the temperature of the room and fridge was taken and recorded each day, although there was one gap in recording for the month of September. The temperatures seen were consistently within recommended parameters.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CDs) and there are strict legal controls to govern how they are prescribed, administered and stored. There was a suitable cabinet in place for the storage of CDs and a CD record book. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in use balanced. The senior staff member told us that two staff signed to record administration of CDs in both the CD book and on MAR charts, and we observed this when we checked the records. CD's were checked for accuracy each week by two senior staff and we saw this recorded in the CD book.

We checked MAR charts and noted that there were no gaps in recording and that codes to record when medication had not been given were used appropriately. There was a sheet held with MAR charts that included a dated photograph of the person and details of any allergies they might have. Any handwritten entries had been signed by two members of staff to reduce the risk of transcribing errors occurring.

There was a good practice procedure in place to ensure the safe administration of Warfarin; people who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered. Details of the person's latest dosage were faxed to the home and this information was stored with MAR charts. We saw that GP's also faxed details to the home to confirm any changes in a person's prescribed medication. This reduced the risk of errors occurring.

Any creams that were prescribed for a person were stored in the medication trolley and administered by the senior member of staff. The pharmacy supplied information to highlight where on the body creams and pain relief patches should be applied. Creams that were considered to be 'homely remedies' were stored in a separate cupboard in a bathroom; the cupboard and the room were locked. These creams were labelled to indicate who they belonged to and care workers applied these creams when they were assisting people with personal care.

There was an effective stock control system in place and we observed that the date was written on packaging to record when it was opened; this was needed to ensure that medication was not used for longer than stated on the packaging. We checked the records for medicines returned to the pharmacy and saw that these were satisfactory.

We checked the arrangements in place to protect people from the risk of infection. The infection control folder included the organisation's policy and procedure on the prevention and control of infection and we saw this document included references to good practice guidance.

Good

Is the service safe?

In addition to this, the folder contained signage ready to display in the event of an outbreak, information about infectious diseases from the Health Protection Unit, advice documents from the Department of Health and an annual statement. The annual statement included a record of any outbreaks of infection during the previous twelve months, information about the home's quality assurance systems and details of staff training on infection control.

The information held about outbreaks of infection recorded the person's symptoms, the name of their GP and when / if the GP had been contacted. The date of recovery was recorded for some people, but not on others.

An infection control audit had been carried out each month, and those we saw recorded any actions or improvements that were needed. However, there was no record to show when identified areas for improvement had been completed.

The laundry room had been clearly divided into 'dirty' and 'clean' areas; one door was used to access the 'dirty' area and another door was used to exit from the 'clean' area. This ensured there was minimal contact between soiled laundry and clean clothes / linen, and reduced the risk of the spread of infection.

Mops and buckets were colour coded to signify the area of the home they were used to clean and were stored in a separate cupboard. The kitchen mop and bucket were stored in a different store cupboard. Again, this reduced the risk of infection.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the Local Authority environmental health department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Information in the infection control folder recorded that all staff had completed training on the prevention and control of infection, and when refresher training was due, they would be completing a workbook on the topic.

Requires improvement

Is the service effective?

Our findings

We saw evidence that newly recruited staff received an induction which incorporated a checklist covering areas such as moving and handling, safeguarding, infection control, health and safety, food hygiene and fire training. As part of the induction process, staff also had the opportunity to shadow more experienced members of staff working in the home before they were included as a staff member on the rota. On the completion of their induction staff then began working towards the care certificate which they complete over a 12 week period. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Care workers were then enrolled on the NVQ Level 2 in care.

The registered manger informed us that the registered provider delivered a range of training to ensure that staff developed the necessary skills and knowledge to effectively meet the needs of the people who use the service. In addition to the 'in house' training provided we were told that staff could also access training provided by the local authority and that the pharmacy linked to the home also provided training on the safe handling and administration of medicine.

The staff we spoke with told us that they felt they were well trained in key areas including moving and handling, safeguarding, fire awareness, infection control and managing behaviours that challenge. We looked at the training records the home held and saw that most staff had received training in the areas that the provider deemed essential and that training had been booked for those members of staff who required a refresher course.

We saw that staff received supervision in line with the homes policy and procedures. These were delivered through one to one supervision, group supervision and staff meetings. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The supervision reviewed any actions which were required form the previous supervision, support responsibilities and learning and performance management; we also saw that staffs strengths and weaknesses were discussed. We saw that key issue were identified and addressed accordingly. For example a medication audit had identified that errors had been made in the recording of the administration of eye drops. This was discussed with the staff members responsible to ensure they were clear of the correct procedure.

The Care Quality Commission (CQC) is required by law to monitor the use of the Deprivation of Liberty Safeguards. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. At the time of our inspection none of the people living at the home were subject to a DoLS authorisation although applications had been made.

The Mental Capacity Act 2005 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.

Staff told us they had received training in MCA and the Deprivation of Liberty Safeguards (DoLS) and were able to show awareness of the key principles of the act. We saw that when decisions were made on behalf of people that the staff team had consulted with the relevant people. However, these decisions had not been made in accordance with the MCA 2005 as there was no record that an assessment of capacity had been completed or that a best interest meeting had been held prior to the decision being made. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf.

We were told that the home had a no restraint policy; however we saw one person's care plan had recently been updated and indicated that minimal restraint could be used to ensure the person was able to receive the personal care they required. There was no documentation available to indicate that a best interest meeting had taken place, who had agreed to this type of intervention or what the precise intervention was.

This was a breach of Regulation 11 (1)(2)(3). Need for consent, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

We addressed this with the registered manager and the deputy manager and they told us that this intervention could only be performed by care workers who had completed the relevant 'Respect' training; this would provide them with the skills to safely carry out this form of intervention. We were told that the type of restraint to be used was low level hand holds which would offer reassurance and help protect staff if the resident lashed out at them. We were reassured that the care plan would be amended to reflect this and that a best interest meeting would be completed before this intervention was used within the home.

People's nutritional and dietary requirements were met. We observed lunch being served and found it to be a relaxed and enjoyable experience. We saw that people were offered a choice of two hot meals and could request other smaller meals, such as sandwiches, if they preferred. We saw staff encouraged people to decide where they wanted to sit for their meal and also ensured that those people who chose to stay in their rooms received their food at the same time as people eating in the main dining room.

When food was served staff offered people a description of what was on the plate ensuring they were happy with their choice. Staff wore aprons over their uniform whilst serving food and we saw there were sufficient numbers of staff in the dining room to ensure that people received the support they needed to eat. People required differing levels of assistance with eating, with some simply requiring their plate to be turned so the food was more accessible, whilst others required full support. Those people who required assistance with eating received this in a respectful and dignified manner.

We spoke with the homes cook and they told us that the food was all prepared away from the premises and delivered on a weekly basis, similar to how food is delivered individually to people's homes. The cook was aware of people's specific dietary requirements and was informed when a person had specific nutritional guidance form a dietitian. The cook was also aware of people's likes and dislikes, which meant they were only served food that they enjoyed.

We saw that people were weighed regularly and weights were recorded in people's care plans and also in a weight records book. The home used the Malnutrition Universal Screening Tool (MUST) to help risk assess people's nutritional needs and whether a person's weight loss was significant. We saw that those who were deemed to be nutritionally at risk were weighed on a weekly basis and the weight charts were handed to the registered manager to review. We saw that people who experienced rapid weight loss or had a loss of appetite were then referred to the dietitian for a nutritional assessment.

Some people had food and fluid recording charts in place to record the quantities of food and drink they were consuming. The registered manger told us they put these in place for people who had a low MUST score; those who had been discharged from hospital and also for people who had recently moved to the home. This was to ensure that people's nutritional needs were being met.

We saw records to confirm that people had health checks and were accompanied by staff to hospital appointments. We saw that people received the treatment they required from the appropriate healthcare professional and that staff were quick to raise concerns as and when they occurred. For instance, where people had lost weight, staff had contacted the GP and dieticians who assisted staff to support people to maintain a healthy diet.

We found the provider had taken steps to make the homes environment more suitable for people with a cognitive impairment. This included the introduction of different coloured bedroom doors, contrasting handrails and toilet seats and clear signage for toilets and bathing areas. We looked in peoples rooms and found that most had been personalised by the person's family to make the room more homely. Personal items had been brought in including items of furniture and personal affects including photographs and pictures.

Good

Is the service caring?

Our findings

Throughout the inspection there was a calm and comfortable atmosphere within the service. It was evident from our discussions that staff knew people well, including their personal history and any likes and dislikes. They told us they had completed training in dementia awareness, dementia and toileting and also care of the dying training. We saw that staff were able to utilise this knowledge in their daily interactions with people living in the home.

As the people who lived in the home were unable to reliably communicate their thoughts on the service, we carried out some observations. We observed staff interacting positively with the people who used the service, making time for them, responding to their queries and questions patiently and providing them with the appropriate information or explanation.

We saw that staff had developed good relationships with the people they cared for and found they knew how to approach people in a variety of ways to ensure that they received the support they required in a prompt and timely manner. We saw people who used the service approach staff with confidence; they indicated when they wanted their company and when they wanted to be on their own and staff respected these choices. During lunchtime, we saw that staff were able to laugh and joke with people, which created a friendly environment for people to enjoy their mealtimes.

Staff carried out their role in a respectful manner. We saw they spoke with people in a polite and pleasant way and it was clear they had a good rapport with the people they cared for. We saw that they called people by their preferred name and always knocked on people's doors before entering. We observed that people were free to walk around the home as they wished and staff allowed them to do so whilst discreetly carrying out checks to ensure that they were not at any risk.

We saw that people were given choice about how their care was delivered. We saw that people were able to get up when they wanted and were told that they could go to bed at a time of their choosing. At mealtimes people were offered a choice of food and could decide where they wanted to eat their meal. They could also choose to eat at a different time if they wished. Staff told us people were given as much choice as possible and would encourage people to choose what clothing they wanted to wear and also how they wanted to occupy their time.

When we spoke with the staff team it was evident that they cared for the people living in the service. They told us that although they were busy, they always tried to make time to stop and talk to people when they were providing care or simply passing them in the home. Our observations supported this.

Most people had relatives and friends who visited and on the day of the inspection we saw they were made to feel welcome by the homes registered manager and staff. As a result, some chose to spend longer periods of time in the home either joining in with the activities that were provided or, in the case of one relative, staying with their husband across lunchtime to provide some support and encouragement with eating. This showed the home understood the importance of families being able to continue their relationships with people who are closed to them.

We spoke with one relative who told us "The staff here really care, people can move around freely and there are smaller lounges where people can sit if they want some time to themselves." Another said "I've always found the staff to be lovely and have no complaints."

Good

Is the service responsive?

Our findings

We looked at the care plans of people who used the service. We saw that they included an initial 'focus' assessment, which identified the elements of the person's care that required the creation of specific care plans and also those elements that required a risk assessment. Lifestyle profiles which described in detail the person's normal daily routines were also included in the care plans. This included key information regarding what time people usually liked to be woken up, what they liked for breakfast and whether they were normally awake throughout the night. We were told that where people were unable to provide the service with this information, that their families would be consulted to assist the home in providing care that the person would be happy with. We saw that 'getting to know you' questions, which were answered by people's friends or relatives, were included in the file.

The care plans we looked at were reviewed on a monthly basis and any changes in need were recorded in the appropriate section of the file. We saw that people's relatives and, when appropriate, the person's health and social care professionals were invited to attend reviews in the home and this was confirmed by a relative we spoke with. Although people who lived in the home were unable to effectively communicate how they wanted their care to be delivered, we saw that the homes staff kept in regular contact with relatives to ensure they were updated with any changes in needs or following any incidents or accidents. One relative told us "I was invited to [Names] review and we discussed the care plan, it gave me the chance to say whether I was happy with the care plan and the care [Name] was receiving."

We found that for people who could display behaviours that challenge, behaviour management plans had been developed. However, we saw that although the plans contained detailed information regarding the behaviours a person may exhibit, the information in relation to how staff should respond to effectively manage this kind of behaviour required more detail. During our discussions with the registered manager and staff we found that they were able to tell us how they would manage each person's behaviour in a way that would keep them and the person safe.

We observed that people were engaged in meaningful occupation. The home employed an activity coordinator who provided a range of activities that were tailored to the needs of the people living in the home. There was an activity diary in place and this enabled those people who used the service and also visitors to the home to see any upcoming events that were taking place. We observed the activity coordinator engaging a group of people in a music and dance activity. This activity was well received with those who were able getting up and joining in with the dancing; others remained in their seats clapping and swaying to the sound of the music. Within this group were a couple who were able to enjoy a dance together, which was clearly an enjoyable moment for both of them.

In addition to the activities provided by the home, we saw that people were supported to engage themselves in those activities that they enjoyed. We observed one person had been provided with a duster and was busy dusting pictures on the walls of the home. Staff were heard praising them, telling them how nice the home looked when they had helped tidy up.

During the inspection we saw that people's friends and relatives were free to visit at any time during the day. Some visitors chose to spend time in the home with their friend or relative, whilst others liked to take them out for lunch or a drive out in the car. This enabled people to maintain relationships with people who were important to them.

The home had a complaints procedure in place. The registered provider told us that they responded to any complaints promptly and that complaints were audited each month. We checked the complaints log and noted that complaints had been responded to appropriately and that people were informed of the outcome. There was evidence that appropriate action had been taken in response to complaints received, and that complaints were used as an opportunity for learning. We spoke with one relative who told us "I've never needed to make a complaint, but if I did I know I can speak with manager or the deputy."

Good

Is the service well-led?

Our findings

At this inspection we found that there was a registered manager in place. The registered manager told us that they felt well supported by the registered provider and that they had strong relationships with both the regional manager and regional director. The registered manager told us that this relationship meant that they were able to operate with a degree of autonomy which enabled them to respond more efficiently to the needs of the people who use the service.

The registered manager encouraged open communication with the staff team by implementing a number of different methods of communication. These included staff meetings, communication books, handover log, communication box (to manage shift swaps and annual leave) and by allowing staff to email them directly with any concerns or issues they may have.

Staff told us they felt supported from all levels of senior management. They told us that they felt they could speak to the registered manager if they had any concerns and that these concerns would be listened to. One member of staff said "They have an open door policy." And "I can go to [name] with anything." Another told us "[Name] is easy going, we have a good relationship." However another told us "[Name] is much stricter, we used to swap and change shifts, but can't do this anymore." Staff were also able to tell us who the regional manager was and said they could speak to them if they felt they needed to.

Meetings with the different staff groups including care workers, night staff, domestics and handyperson were held so they could focus on specific issues for each group. We also saw that meetings were held for managers and regional managers to enable the sharing of best practice and also to address any concerns at provider level.

We saw that meetings took place on a monthly basis for people living in the home. These meetings were used as an opportunity to discuss any events that were due to take place, capture any suggested activities people may want to try and also to raise any concerns they may have. We also saw meetings with relatives had taken place, although these were not held as frequently as relatives were also invited to meetings for people living in the home. One relative said "I always get invited to the residents meetings."

In addition to the meetings, the home carried out surveys with the staff and relatives of people living in the home. We saw that these surveys provided an opportunity for people to feedback to the manager any compliments or suggestions that could improve the quality of care provided. We saw that as a result of a survey regarding activities in the home, the registered manager had employed an activity coordinator to focus specifically on ensuring appropriate activities were delivered in the home.

The registered manager had implemented a newsletter, which informed people living in the home and visitors of what activities were planned for the month ahead and any celebrations or special occasions such as birthdays and 'world baking day'. We also saw that this information was displayed on the television in the homes foyer.

We saw that the provider had audits in place to check that the systems at the home were being followed and that people were receiving appropriate care and support. We saw that regular audits were taking place in relation to infection control, care plans, incidents and accidents, medication, activities and the homes environment. We found that these audits were helping to highlight any areas that required improvement and that these were acted upon by the registered manager.

The home had a statement of purpose that was available for staff, people living in the home and relatives to view. This provided a clear philosophy of care that all who were employed were expected to adhere to. This statement also provided clear guidance for relatives on what is included in the homes fees and also how they could make a complaint if necessary.

The registered manager told us that the culture of the home was very important and that this was now included in the induction process that all new starters undertook prior to starting to work within the home. This was implemented to ensure that staff were aware of how their attitude towards their role as a care worker and conduct whilst at work could affect the environment that people lived in.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who used the service were not always protected against the risks associated with receiving care and treatment they had not consented to or which had not been agreed in a best interest forum. Regulation 11 (1)(2)(3)