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Hollybank Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 27 September and 6 October 2016, the first day was unannounced. At our last inspection in May 2014 the provider met the regulations we inspected.

Hollybank Residential Home is a privately owned care home for up to 17 older people who require residential care and may be living with dementia. Accommodation is arranged over three floors and there is stair lift access to one floor. Communal areas include a lounge, conservatory, kitchen and dining room with bathroom and toilet facilities throughout. There is also an enclosed rear garden with sloping lawn and paved area for people to access. At the time of our inspection there were 17 people using the service.

Under the conditions of registration the home is not required to have a registered manager as it is owned by an individual provider. There was an established manager who had worked at the service for over twenty years. The registered provider was in the home each day and was actively involved in how the home ran.

People using the service and their relatives told us they felt safe and well cared for. Staff knew how to recognise and report any concerns they had about the care and welfare of people and how to protect them from abuse and harm. Where risks were identified, there was guidance on the ways to keep people safe in their home and in the local community.

The environment was safely maintained and people had the equipment they needed to meet their assessed needs. Individual bedrooms were personalised and furnished to comfortable standards.

The provider followed an appropriate recruitment process to check staff were suitable to work in a care setting. Staff received an induction and relevant training to support people with their care needs. This was followed by ongoing refresher training to update and develop their knowledge and skills. Staff also undertook training courses specific to people's needs such as dementia awareness, diabetes and understanding depression.

The staff team had worked at Hollybank for a number of years and knew people well. There were positive and caring relationships between staff and people who lived in the home and this extended to relatives and other visitors. Staff treated people who used the service and their guests with respect and courtesy. They were caring, patient and maintained people's privacy and dignity.

People's needs were assessed and planned for and staff had accurate information about how best to meet people's needs. People's wishes, preferences and beliefs were reflected in their care plans. There was information about people's social links and relationships with family and friends. Staff were responsive when people's support needs or circumstances changed and care records were updated appropriately.

People's rights were protected because the provider acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This legislation is intended to ensure people receive the support they

need to make their own decisions wherever possible. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

Where people lacked capacity to make decisions, staff were aware of how to support them in line with the law. Families and professionals were consulted about people's care so decisions could be made in the person's best interests. Appropriate applications had been made to the supervisory body to restrict people's liberty where required.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were provided with homemade, freshly cooked meals. When people were at risk of poor nutrition or dehydration, staff involved other professionals such as the GP or dietician.

Medicines were managed safely and people received their medicines as prescribed. The service worked closely with external professionals to promote people's health and wellbeing and meet their needs. Appropriate referrals were made when people became unwell or required additional services.

The manager had been in charge at Hollybank for a long time. She knew people and staff well and had good oversight of everything that happened at the service.

People and their relatives felt involved in the way the home was run and were encouraged to express their views and opinions. They knew how to complain and make suggestions, and were confident their views would be acted upon.

Management and staff completed regular audits to check the quality and safety of the service. Where improvements were needed or lessons learnt, action was taken.

We found areas within the home that could be decorated and equipped more suitably for people living with dementia. We have made a recommendation about improving the environment to provide more engagement and stimulation.

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. People felt safe and staff knew about their responsibility to protect people from the risk of abuse and harm. Risks associated with people's care needs were identified and steps were taken to minimise these and keep people safe.

Staffing levels were sufficient to meet people's needs and the provider followed an appropriate recruitment process to employ suitable staff.

The environment was clean and maintenance took place when needed.

Medicines were managed safely and people received these as prescribed.

Is the service effective?

Good

The service was effective. People were supported by staff who had the knowledge and skills to meet their individual needs. Staff received the training and support they required to fulfil their roles.

People's rights were protected because the provider acted in accordance with the principles of the Mental Capacity Act 2005. Staff understood their responsibilities should a person be unable to make a decision independently or if someone was being deprived of their liberty.

The environment did not fully meet the needs of people who used the service living with dementia. The provider recognised the need to address this and had plans to improve.

People were supported to eat and drink well and received the support and care they needed to maintain their health and wellbeing. Staff sought healthcare advice and support for people as required. Relevant professionals were involved where necessary.

Is the service caring?

Good

The service was caring. People told us staff were caring and

supportive and always respected their privacy and dignity.

People and their relatives were involved in making decisions about their care. Staff knew people well and had developed positive relationships with them.

The service worked closely with families and relevant professionals so that people received dignified care at the end of their lives.

Is the service responsive?

Good

The service was responsive. People's needs were assessed before they came to live at the service and their needs were monitored and reviewed accordingly. Staff responded promptly when there were changes to people's health or wellbeing.

People received individualised care that was tailored to their needs and preferences. Care records were person centred and described people's needs and risks and how to manage these.

Activities and entertainment were available although people felt these could be improved. The service had plans to provide more stimulating and meaningful activities for people living with dementia.

Arrangements were in place for dealing with complaints and responding to people's comments and feedback.

Is the service well-led?

Good

The service was well-led. People were positive about how the service was run. The registered provider and manager showed effective leadership and encouraged people, relatives and staff to share their experiences of the service.

There was open communication between management and the staff team. Staff felt supported in their roles and in developing best practice.

Suitable audit systems were used to monitor and develop the quality of the service. Action was taken where needed to improve the care and support people received.

Hollybank Residential 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to our visit we also reviewed the information we held about the service. This included inspection history, any safeguarding or complaints and any notifications the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law.

This inspection took place on 27 September and 6 October 2016 and the first day was unannounced. The inspection was carried out by one inspector 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.

We spoke with eight people using the service, two relatives, the registered provider, the manager and four members of staff.

We reviewed care records for five people who used the service. We checked three staff files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits and health and safety records. We also checked how medicines were managed and the records relating to this.

Following our inspection the manager provided us with information we had requested about staff training and quality assurance findings.

Good

Is the service safe?

Our findings

People told us they felt safe living at Hollybank and staff were kind and treated them well. One person said, "I know nobody can hurt me" and another person commented they felt safe because "the carers are here." Relatives we spoke with were confident that staff kept their family members safe. One relative said, "Definitely safe…. [my relative] is happy here, never had any problems."
At a recent residents meeting, people were reminded about what abuse was and how to report any concerns.

People were protected from the risk of abuse and avoidable harm. Staff knew what abuse meant and were knowledgeable in recognising signs of potential abuse and the relevant reporting procedures. They had attended safeguarding training and updated this every year. There were contact numbers displayed in the home that staff, people who used the service or visitors could use to report any concerns regarding abuse. Records held by the home and CQC showed the service had made appropriate safeguarding referrals when necessary and that staff worked in partnership with the local authority and other agencies to protect people.

Risks to people's health and welfare were identified and managed appropriately. Where a risk was identified, there was clear guidance included in people's care plans to help staff support them in a safe manner. Risk assessments were personalised and covered the risks associated with people's care needs such as mobility, skincare, nutrition, continence and falls. One example included, "Skin very thin, likely to bruise or tear" and explained how staff should support the person when providing personal care. Another identified a person was at risk of urine infections and staff should encourage fluids. There was a stair lift in the home and staff had assessed the support people required to use this safely. One person liked to go out independently each day and this was supported. Staff were aware of the risks associated with people's individual needs and knew what action to take to minimise these.

Records of accidents and incidents we reviewed included an analysis of what had happened and any action taken to prevent reoccurrence. People's weight and falls were monitored and action had been taken to address any changes identified. For example, other agencies such as the falls intervention team or dietician became involved when needed.

On the first day's inspection we found a fire exit door was locked and there was no key available. We brought this to the attention of the provider who promptly located a spare key and acknowledged this could have placed people and staff at potential risk. By the time of our second visit the manager had taken further action and arranged for emergency key boxes to be installed at all fire exits.

The premises were maintained and checked to help ensure the safety of people, staff and visitors. Appointed contractors completed regular checks and servicing of fire, gas and electrical safety and equipment was checked to ensure it was safe for people to use. Records were up to date and staff completed health and safety checks which included a walk around the building to monitor for any hazards. A handyman was employed to undertake essential repairs and maintenance where necessary.

All areas of the home were clean and smelt fresh aside from one of the basement bedrooms. The manager informed us this person's needs had changed and there were plans to replace the carpet with more suitable flooring. Anti-bacterial hand gel was available throughout the building. Protective clothing was available to staff and appropriate arrangements were in place for the safe storage and disposal of clinical waste. We saw that an infection control audit had been undertaken by the local authority in June 2015 and the minor recommendations had been addressed.

There were arrangements in place to deal with unforeseen events. The provider had policies and procedures for contingencies such as utility failures or in the event of a fire. Staff were trained in first aid and were able to contact the manager or provider on call if there was an emergency out of hours. People had up to date personal emergency evacuation plans (PEEPs). These outlined the support people required should they need to leave the building in the event of a fire or other emergency.

The provider undertook the required recruitment checks before staff started work. Staff records included details of previous employment, two written references and a check with the disclosure and barring service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record. There was also information about employees' physical and mental health and a record of interview questions held on file.

People felt there were enough staff to support their needs. People said staff responded promptly to any request for support and when they needed to use their calls bells. One person told us, "I did once and they came quickly" and another person said staff responded "almost immediately." Relatives we spoke with shared similar views and one told us that staff were "always around" when they visited. There was an established manager and staff team which meant people experienced consistent care and support. The home did not use agency staff and unexpected absences such as sickness and emergencies were covered by existing staff. Staffing levels comprised of three staff throughout the day with one waking night staff and an on call sleep-in staff which was usually the manager who lived on site in separate accommodation. Separate domestic staff were employed. The manager and provider also worked as part of the staff team and were available to provide support if required.

We found that staffing levels were safe although we saw instances where staff were not present in the lounge when some people using the service made derogatory comments about other people in their presence. These included, "just ignore her", "she's attention seeking" and "oh just look at her" when one person became upset and started crying. On another occasion these people shouted directions at one person when they became confused and asked where the toilet was. We discussed this with the provider and manager who agreed to speak with the people concerned and ensure staff monitored the situation.

The manager told us staffing levels were based on the dependency needs of people who used the service although there was no evidence to demonstrate how they assessed this. Following our inspection the manager sent us information about how care staff hours were calculated to meet people's needs. This showed that staffing levels had been reviewed and where individual needs directed, staffing levels were adjusted. For example, an additional member of staff was allocated three days a week to undertake activities with people. The manager also confirmed they had arranged for extra local authority funding for a person who required periods of one to one care.

People told us they received their medicines when they needed them. One person said, "I use a pump [inhaler] every day and they make sure of that." Another person told us staff offered a painkiller if they requested it. Staff we spoke with were clear about their roles and responsibilities in relation to medicines and had completed medicine administration training. We observed a member of staff demonstrate safe

practice whilst administering medicines during lunch.

There were risk assessments in people's records to show whether they were able to manage their medicines. Individual medicine profiles included details about the name of the medicine, the dose and date of prescription. We discussed adding information about the reasons why people were prescribed their regular medicines with a member of staff. They agreed to review the profiles to include these. Where people needed medicines 'as required' or only at certain times there were guidelines about the circumstances and frequency they should be given. People's prescribed medicines were reviewed by relevant healthcare professionals as necessary.

Where people received covert medicines, appropriate action had been taken to support the decision making process. (Covert is the term used when medicine is administered in a disguised way without the knowledge or consent of the person receiving it.) There were details about the reasons why covert medicines were required and how they should be administered. Mental capacity assessments were completed and best interests meetings were held involving relevant family or representatives and healthcare professionals.

Medicines were kept in a lockable metal cabinet in the office. The home used a monitored dosage system with medicines supplied by a local pharmacist. People's medicines administration records (MARs) included details of prescribed medicines and instructions for their administration. For one person we noted a regular medicine had not been signed as administered for several weeks. We discussed this with a member of staff who identified this was a recording error and that the person had received their medicines. Staff told us they completed monthly audits to check people's medicines although we noted that the last audit was undertaken in May 2016. We were told the staff member who had responsibility for these audits had to take leave unexpectedly and an immediate medicines audit would be carried out. At our second visit, we found all medicines had been checked and appropriate action taken where needed. For example, staff had contacted the GP to verify people's current prescriptions and the pharmacy to make minor amendments to the MARs.

Good

Is the service effective?

Our findings

People were cared for by skilled staff who understood their care and support needs. New staff completed a structured induction which involved one to two weeks of shadowing another member of staff, depending on experience. The provider used the Care Certificate which is a nationally recognised framework for good practice in the induction of staff. Existing staff were due to complete a self-assessment to review their competencies against the expected standards. Staff were supported with training in order to keep up to date with best practice and extend their skills and knowledge in meeting people's needs. The provider had a training and development programme for staff that included mandatory learning. Topics included first aid, fire safety, food hygiene, health and safety, infection control, manual handling, and safeguarding.

Since our last inspection, the home had accessed a range of local authority training to keep up-to-date with best practice and to help enhance the care people received. This had included training in Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), dementia awareness, understanding depression, equality, diversity and dignity as wells as nutritional care & monitoring weight loss. Following our inspection the manager confirmed staff had attended a course on continence and good skin care. There were also plans for staff to attend person centred dementia training over the next few months. The manager used an electronic training record to monitor the training staff received and check they were up to date.

Staff received on-going support and development to ensure they were competent in their roles. One to one supervision meetings and yearly appraisals took place regularly with the manager. Staff supervision records were detailed and included discussions about people using the service. One member of staff told us they felt supported and could report any concerns to the manager.

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.

Care records demonstrated that people's consent and ability to make specific decisions had been recorded in their care plans. People and/or their relatives were involved in regular discussions about their care and had been asked to contribute to their care records. Where people had been assessed as lacking capacity to make certain decisions, records were in place to show that the relevant healthcare professionals and those close to the person had been consulted. This was so their views could be sought and any decision they

made on behalf of the person was in their best interests.

The manager had assessed where a person may be deprived of their liberty and submitted applications as necessary to the supervisory body (local authority). For example, the front door was locked and could only be opened by a keypad entry system operated by staff. Appropriate DoLS authorisations were in place for some people as it was unsafe for them to access the community unaccompanied. Staff were aware of people who were subject to DoLS and the reasons for any restrictions in place. There was information and guidance available to staff about the MCA and how this legislation impacted on the care they provided to people.

Care plans included details about people's nutritional needs as well as their favourite foods and specific diets. Records showed that staff monitored any significant changes in people's weight, appetite or intake and contacted the GP if necessary. Other professionals, such as the dietician, were involved in people's care if this met an identified need.

People were complimentary about the food and told us they could choose where to eat their meals. Comments included, "Very good…It's cooked nicely…. really very nice", "It's quite nice they have a lot of pasta which I'm not used to" and "The food is good." A visiting relative told us, "Different things everyday", "they ask what you want" and "a good choice of food." Another relative said, "[My relative] likes the food, always gets a choice." Another person said, "If I feel a bit peckish they will always do me something even if it's a soup in a bowl." One person told us the meals did not always meet their cultural preferences. We discussed this with the manager who told us they would remind staff to offer the person their preferred dishes at every mealtime.

We joined people in the dining room for lunch which was served over two sittings. Those people that needed assistance to eat their meals were supported first. The mealtime experience was calm and unhurried. Staff could provide the level of support people needed, giving them sufficient time to enjoy their food. Staff made sure people were comfortable and gave encouragement where people were reluctant to finish their meals. The meals looked balanced and healthy and people were given a choice. Alternatives were made available if they did not like the options presented and staff provided clear explanations and visual choices where appropriate. People were asked if they wanted further helpings and were offered a choice of desserts. The daily menu was displayed on the dining room door and reflected a varied and nutritional diet. Hot and cold drinks were also offered to people throughout the day.

People were supported with their healthcare needs and able to access relevant services for routine checks, advice and treatment when needed. One person told us, "If we need, the doctor does come along" and another person said, "I get a chiropodist calling in; doctor calls in when I need him." Following a person's admission, a new patient check was arranged with the GP. Care records reflected individuals' needs and records of all health care appointments were maintained. We saw people had seen other specialists where appropriate and staff followed any advice provided by professionals. Where people had specific health conditions such as diabetes, there was information available alongside the care plan which explained more about the condition and how to support someone with it.

There were accessible toilets and bathrooms situated throughout the building. Facilities were equipped with sufficient aids and adaptations to meet people's physical needs such as raised toilet seats and hand rails for support. People had mobility aids and other specialist equipment to promote their independence and there was stair lift access to the first floor.

We found further work could take place in the home to promote engagement and wellbeing for people living

with dementia. In a corridor of the home, there were some sensory items that people could touch, look at and feel. This included tactile wall coverings, different types of materials for people to touch and a display screen with a fish aquarium. In other areas of the home however there were no pictures, objects or accessories that provided people with stimulation or links to past memories and activities. We recommend that the service consider current guidance on improving the environment for people living with dementia.

Good

Is the service caring?

Our findings

People spoke positively about the support they received and the caring nature of staff. One person told us, "Can't ask for better" and other people described staff as, "very good" and "very nice." Relatives shared similar views. One told us their relative was "well looked after." Another relative spoke about staff as "genuinely caring" and told us, "They are very friendly and often smiling."

Interactions between staff and people were positive and caring. Throughout our visit staff supported people with kindness and compassion. Their approach to people was respectful and patient. We observed one staff member reassure one person when they became confused about whether they had taken their medicines. The member of staff sat and chatted with the person, taking time to explain what the medicines were for and why they needed them.

When people first moved to the service, they were asked about preferred daily routines and what level of assistance they required. We saw information about personal preferences, likes and dislikes, what helped them relax, kept them happy and things that were important to them. One example included, "I am quite grumpy in the mornings when I first wake up and can reject assistance. Staff should give me a cup of tea and leave me for a short while, try again later." People were also given information about the standard of care to expect and the services and facilities provided at Hollybank.

Care plans included background information about people's lives prior to living at Hollybank. Relatives told us they were asked about their family members' personal histories and interests. One told us, "Staff have taken a very detailed résumé of her life." Staff showed knowledge about the people they supported and were able to tell us about people's individual needs, preferences and interests. Their comments corresponded with what we saw in the care plans.

People were encouraged to maintain links with people who were important to them. People and visitors we spoke with confirmed they were always made to feel welcome at Hollybank and could speak to the manager or owner at any time. Relatives told us how they were consulted about their family member's care where the person was unable to make their own decisions and were asked for their opinion on how the care should be provided. They confirmed that staff always kept them up to date with the health and welfare of their family member which was important to them. There were quiet areas, including a conservatory, where people and their visitors could meet in private. We also saw a number of complimentary letters about the service from relatives of people who had stayed at Hollybank.

People we spoke with told us staff respected their privacy and dignity. People received personal care in the privacy of their bedroom or bathroom with doors closed. Where people chose to have their door open or closed, their privacy was respected. We observed that staff always knocked on people's bedroom doors and waited to be invited in. We saw that people were provided with appropriate protective clothing when eating and drinking. The manager, registered provider and a member of staff were dignity champions.

People were encouraged to bring in their own items to personalise their bedrooms. Rooms we saw were

furnished with pictures, photos and other items of sentimental value which helped create a homely environment.

Care records showed that people had discussed their wishes about how they wanted to be cared for at the end of their lives. Staff were in the process of undertaking end of life care training. This was facilitated by the local hospice team, who also provided advice and support to the home about end of life care.

People's confidential information was kept private and secure and their records were stored appropriately. Staff knew the importance of maintaining confidentiality and had received training on the principles of privacy and dignity and person centred care.

Good

Is the service responsive?

Our findings

People and their relatives told us the service was responsive and staff were flexible in meeting their needs. One person said, "They are there if you want them" and another person commented, "Staff would help if needed." One relative told us, "They sit and play cards with [my relative] when he can't sleep at night." Another relative told us staff took their family member out shopping which the person enjoyed. We observed staff checked on people who were in their own rooms at regular intervals to see if they were comfortable or needed anything.

Assessments took place before people moved to Hollybank to determine if the service could meet their care needs and expectations. We looked at an assessment for the person who had moved in most recently. The assessment considered all aspects of the person's life, including their background, hobbies, social needs, preferences, past medical history, health and personal care needs and areas of independence. It included details of specific care areas such as nutrition, skin care and mobility. Relatives had also been consulted about their family member's preferences and background history.

Information from the assessments were used to develop care plans based on the person's needs. Plans reflected a holistic approach to care and included the support people required for their physical, emotional and social well-being. They were personalised and included information on people's life experiences, interests, hobbies and likes and dislikes. People's care plans explained what a person could do for themselves and what support they required from staff. Care records reflected how specific health conditions might impact upon people's care and how living with dementia affected people's daily lives. For example, how a person living with dementia communicated and how staff should respond when a person became upset or disorientated. Guidelines about diabetes or management of pressure sores were available to support staff to provide appropriate care. Short term care plans were written when people developed an acute condition such as a urinary infection.

People's diverse needs were understood and supported. Care plans included details about people's needs in relation to age, disability, gender, race, religion and belief and sexual orientation. People were asked about their cultural food preferences as part of the admission process. Consideration was given to people's religious and spiritual needs and individuals were supported to practise their faith either within the home or local community.

Records showed people's needs and abilities were reviewed every month and their care plans were updated when their needs changed, for example after a return from hospital. We saw that people's placements and care plans were reviewed regularly. Reviews took account of health, social and emotional changes and involved people's care managers, family and other representatives as necessary to represent people's interests. Staff made appropriate referrals on behalf of people who used the service when needed. For example, the service sought the support of healthcare professionals such as the falls intervention team and community mental health team. Timely referrals had been made to the district nursing service and GP where necessary. Records confirmed that instructions made by other health care professionals had been carried out.

The staff had knowledge about how each person liked to receive their personal care and what activities they enjoyed. They were able to tell us what they would do if people were unwell, unhappy or if there was a change in a person's behaviour. These details were included in the care plans. Staff completed daily plans and shared information at each shift change to keep up to date with any changes concerning people's care and support.

People told us there were activities organised and they enjoyed visits from outside entertainers. On the second day of our inspection an entertainer held a singing session. Written information about the weekly activity timetable was displayed on the lounge door. The programme of activities included arts and crafts, quizzes, total fitness, cake decorating and music sessions. Five people we spoke with felt activities could be improved. Comments included, "Not a lot we just sit and chat", "There's not much to do" and one person said they spent their time "just sitting and watching the box, if they [staff] come and talk to you, you can talk." Some people told us they preferred not to get involved in the activities and staff respected their choice. One person told us they preferred their own company and stayed in their room.

During our first visit the planned morning activity of a visit from the hairdresser was cancelled and no alternative activity was put in its place. In the afternoon there were no organised activities and people spent time watching the television. Aside from the sensory area in the corridor there were few pictures, furnishings or other items to provide stimulation and interest for people living with dementia. We spoke with the manager about ways to enhance people's surroundings by providing reminiscence style equipment such as memory boxes for people to investigate or dolls and soft toys or furnishings for them to touch and hold. The provider and manager acknowledged this and agreed to look at ways to provide more meaningful activities for people living with dementia. Planned improvements in the PIR identified there were plans to address this. Following our inspection, the manager also confirmed they had reviewed the staffing levels and allocated an additional staff member to undertake activities with people three days a week. We will check for progress at our next inspection.

People and relatives we spoke with told us they were able to express their views and give feedback about the service. This was done through monthly care plan reviews, meetings held at the home and annual surveys. Prior to a review meeting, people and relatives were provided with a questionnaire which asked for feedback about areas such as menu choices, the environment, comfort, activities and how the service could improve. Resident meetings were held every two months and people were encouraged to give their opinions about their care and the conduct of staff. At one meeting we noted staff checked if people felt warm and comfortable in the cold weather.

People and their relatives told us they knew how to make complaints about the service and were confident any issues would be addressed. They told us they had not had cause to complain but would tell staff if they had any concerns. One person said, "Oh yes when I have, they have sit and listened." A relative told us, "Never had to, as long as [my relative] is happy, I'm happy." Information about how to make a complaint was displayed and a comments/suggestions box was available to people in the hall. The procedure included details about other relevant organisations if someone wished to raise a concern outside of the home. The manager kept a record of complaints and concerns and how these had been dealt with. There had been one complaint about the service in the last twelve months. Records confirmed this was resolved and the complainant provided with a written response to their concerns.

Good

Is the service well-led?

Our findings

The service was managed by an individual registered provider and a manager who lived on site in separate accommodation. The registered provider was in the home each day and was actively involved in how the service ran. Both the manager and registered provider recognised their roles and responsibilities and worked together to monitor and develop the quality of the service. People and their relatives felt the home was well run and the management and staff were friendly and approachable. A relative told us, "The manager is diligent" and described the home and staff as "proactive."

There was a positive culture in the service. Interactions between people, their relatives and visitors, the staff and management were friendly and welcoming. We observed the staff all worked well as a team to provide people with good care. The staff team knew people well and told us they felt supported by the manager and provider. The service had a clear set of values which included privacy, dignity, independence, civil rights and choice for people. Staff were aware of these values and applied them in their practice.

The manager promoted and encouraged open communication amongst everyone who used the service. There were good relationships between people, relatives and staff, and this supported effective communication on a day to day basis. Daily handovers took place so that staff were kept up to date with any changes to people's care and welfare. Staff meetings were held every two months and included discussions around the care provided and any matters that affected the service, including issues staff wanted to raise. Meetings were also used to share learning and best practice and additional meetings were held when necessary. For example, the manager and staff had discussed responsibilities and duties for administering medicines following a medicines error. All meetings were recorded and any action agreed to be taken was monitored until completion.

We reviewed the home's latest quality assurance development plan which included findings from feedback surveys sent to people using the service and their relatives in May 2016. The survey asked people and their family members/representatives to rate and comment on aspects of the service. This included views about the staff, people's daily care, cleanliness of the service and the management. Responses confirmed that people rated the service provision as 'good' or 'excellent.' The plan explained how the home monitored service provision and the action taken in response to the few comments raised.

Prior to our inspection, the provider completed a Provider Information Return (PIR) and returned it to us within the agreed timescale. The PIR gave us good information about how the service performed and what improvements had taken place or were planned. For example a new sensory/dementia area had been introduced and a new music and entertainment system had been purchased. People were provided with a wider variety of meals and large picture menus to help them make choices. There were plans to upgrade the rear garden area and its access.

There were a range of audits and checks to monitor the quality of the service. These included checks on aspects of care such as medicines, care plans, staff training and supervision, health and safety and the presentation of the environment. Records showed what action was being taken in response to any

shortfalls.

The manager and provider worked in partnership with other professionals to help ensure people received the most appropriate support to meet their needs. Care records showed how the service engaged with other healthcare agencies and specialists to respond to people's care needs and to maintain people's safety and welfare. In March 2016 Healthwatch England undertook a visit and their report reflected positive experiences for people. The manager told us the local authority carried out a monitoring visit in September 2016 and found no concerns. During our inspection, the registered provider and manager welcomed any guidance we gave and suggestions made were acted upon. They also took prompt action to address the few issues we identified during the inspection.

Registered persons are required by law to notify CQC of certain changes, events or incidents at the service. Before our inspection we checked the records we held about the service. We found that the manager had notified us appropriately of any reportable events.