Embrace (UK) Limited

Arthur's Court

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 6 January 2017. Arthur's Court is registered to provide accommodation with nursing care for up to 40 older people. There were 30 people using the service on the day of our inspection.

We last inspected the service in July 2013 and the service was meeting the regulations of the Health and Social Care Act (2008) we inspected.

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

There were adequate staffing levels to meet people's needs. There had been staff shortages during 2016 and the service had needed to use agency staff to cover gaps. At the time of the inspection the service had almost a complete full team of staff and were not so reliant on agency staff. People felt there were adequate numbers of staff on duty and that staff responded to bells promptly.

People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. Staff had received training and developed skills and knowledge to meet people's needs. Staff relationships with people were caring and supportive. They delivered care that was kind and compassionate.

Measures to manage risk were as least restrictive as possible to protect people's freedom. Medicines were safely managed and procedures were in place to ensure people received their medicines as prescribed. Topical cream charts to guide staff were not always clear. However following the inspection we received assurances from the registered manager that improvements had been made.

Care plans were personalised and recognised people's health, social and psychological needs. We raised concerns with the registered manager that care plans did not always cover all aspects of people's needs. Following the inspection the registered manager and deputy manager reviewed everyone's care file. They put in place care plans where needed to ensure all people's health needs were covered.

People's views and suggestions were taken into account to improve the service. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments had been completed. However it was not always clear how best interest decisions had been made in line with the MCA. People's families had been

asked to consent but it was not always clear how this decision had been made.

People were supported to eat and drink enough and maintain a balanced diet. People were positive about the food at the service.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. Where there were concerns or complaints, these were investigated and action taken. The premises and equipment were managed to keep people safe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to recognise signs of abuse and how to report suspected abuse.

There were sufficient staff on duty to meet people's needs.

Appropriate risks to people were identified and reduced as much as possible.

People were protected by a safe recruitment process which ensured only suitable staff were employed.

Accidents and incidents were monitored and any trends identified.

Is the service effective?

Good

The service was effective.

Staff asked for consent before they carried out any personal care. The Mental Capacity Act (2005) was followed. Improvements were needed to demonstrate how best interest decisions were recorded and why consent from relative was sought.

Staff received regular training, supervision and appraisals.

Advice and guidance was sought from relevant professionals to meet people's healthcare needs.

People enjoyed a varied and nutritious diet.

Is the service caring?

Good

The service was caring.

Staff were caring and kind. They respected people and treated them as individuals and included them in decision making.

Staff recognised the importance of maintaining family contact. Visitors and friends were welcomed.

Is the service responsive?

Requires Improvement

The service was responsive.

People's needs were assessed. Care plans were developed to meet people's needs. However improvements were needed to ensure there were care plans in place for all identified needs. Action was taken to put these in place.

People had been involved in planning their care. Daily care records were not always written in a personalised way.

There was an effective complaints procedure in place. People knew how to make a complaint and they had opportunities to offer feedback about the service.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively about the registered manager and deputy manager and said they worked well with them. The management was visible at all levels at the service and inspired staff to provide a quality service.

People's views and suggestions were taken into account to improve the service.

There was an effective audit program to monitor the quality of care provided and ensure the safe running of the service.

Arthur's Court

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 January 2017 and was unannounced. The inspection team consisted of an inspector and two specialist advisors who were registered nurses and had an in-depth knowledge in care of older people.

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. We reviewed the information included in the PIR along with information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met and observed the majority of the people who lived at the service and received feedback from eleven people who were able to tell us about their experiences. We also spoke with four visitors to ask their views about the service.

We spoke to 14 staff, including the registered manager, deputy manager, senior care workers, and care workers, the cook, housekeeping staff, a maintenance person and the administrator.

We reviewed information about people's care and how the service was managed. These included six people's care records and everyone's medicine records, along with other records relating to the management of the service. These included staff training, support and employment records, external agency audits, quality assurance audits and minutes of residents and team meetings. We also contacted health and social care professionals and commissioners of the service for their views. We received a response from four health and social care professionals.

Good

Is the service safe?

Our findings

People felt safe at the service. Comments included, "Yes very"; "I feel safe"; "I am quite happy here"; "No one has ever been unkind to me here" and "absolutely."

People received their medicines safely and as required. Comments included, "Yes I get them on time. They come and give them to me" and "They are very good." People's medicines were administered by nurses. The nurses had their competencies assessed by the registered manager or the deputy manager. The deputy manager was seen during our visit administering medicines in a safe way. They had a good understanding of the medicines they were giving out to people.

Where people had medicines prescribed as needed, (known as PRN), protocols were in place for some, but not all, about when and how they should be used. Following the inspection the registered manager confirmed they had reviewed everyone's medicines and protocols had been put in place for all PRN medicines.

There was a system in place to monitor the receipt and disposal of people's medicines. There was a procedure to monitor daily the temperature of the medicine fridge and that it was at the recommended temperature. Medicines at the service were locked away in accordance with the relevant legislation. Medicine administration records were accurately completed and any signature gaps had been identified by the nurses and action had been taken to ensure people had received their medicines. The pharmacy that supports the service had undertaken an audit in December 2016 and raised no significant concerns. However they had highlighted the temperature of the medicine fridge on one occasion was below the recommended guidance. We found the medicine fridge temperature had been within the recommended range since their visit.

Improvements were needed in relation to the administration of topical creams, as this was not always safe. Prescribed creams were recorded on people's medicine administration records (MAR). The information was transferred on to a topical cream chart by care staff to be signed when topical creams had been administered. This guided staff which cream to use, where it should be applied and the frequency of the cream application. However the information on the cream charts was not always accurate and as prescribed by the doctor. The registered manager wrote to us after the inspection and said a nurse had reviewed everyone's cream charts to ensure they accurately recorded what was prescribed. They said a nurse would take on the responsibility to populate the cream charts each month.

Our observations and discussions with people and visitors showed there were sufficient numbers of staff on duty to keep people safe. Staff were seen to be busy but appeared to have time to meet people's individual needs. During our visits call bells were answered in a timely way. People said staff responded quickly to call bells and the registered manager undertook bell audits to ensure bells were responded to promptly. One person said, "If I ring my bell they respond in no time." Staff said they felt there were adequate staff to meet people's needs the majority of the time, but said there were times when more would be helpful. One care worker said, "Always enough staff."

The staff schedule showed during the morning there was a nurse on duty, with a designated senior care worker and four care staff who might also be senior care workers. In the afternoon this was reduced by one care worker. At night there was a nurse and two care workers. They were supported by housekeeping staff who also undertook laundry duties. There was also a maintenance person, cook, kitchen assistant, activity person and an administrator who also interacted with people while undertaking their roles.

During 2016 we were told there had been a staff shortage at the home. When asked why there were empty beds at the service the deputy manager said, "We did have staff shortages so we stopped admissions, now we have staff we have started admitting again." Staff had undertaken additional duties and the provider had needed to use the services of local care agencies to cover gaps. The registered manager said the use of agency nurses and care workers at the service had decreased considerably. They went on to say they nearly had a full team of nurses and once they had completed their inductions would have delegated responsibilities. One care worker said, "It is much better now. Before we used a lot of agency which was quite hard, so much better now."

Staff were aware of their responsibilities with regard to protecting people from possible abuse or harm. They had received training about safeguarding people and were able to describe the types of abuse people may be exposed to. Staff were able to explain the reporting process for safeguarding concerns. They were confident action would be taken by the registered manager about any concerns raised. For example one care worker said, "I would tell (registered manager) he would take action. He wouldn't allow that here." They also knew they could report concerns to other organisations outside the service if necessary. The registered manager was aware of their responsibilities in regard to safeguarding people.

The recruitment and selection processes in place ensured fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken. Any employment gaps had been explored. In addition, pre-employment checks were done, which included references and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisation's policies and procedures.

People were protected because risks for each person were identified. Risk assessments about each person were undertaken which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin integrity, nutrition and manual handling. People assessed as at risk of developing pressure sores had equipment in place to protect them. This included pressure relieving cushions on their chairs. Risk assessment were also undertaken for the environment and staff actions. For example risks was assessed regarding tall heavy furniture not being stable, as a result all furniture had been secured. Other areas which had been risk assessed included, safety when supporting people in vehicles, footwear, catering environment and electric profiling beds

The environment was safe and secure for people who used the service and staff. A designated maintenance person over saw the maintenance at the service. They undertook regular checks of the service which included checking water temperatures, checking bed rails, portable appliance testing (PAT) and checking wheelchairs. External contractors undertook regular servicing and testing of moving and handling equipment, electrical and lift maintenance. Fire checks and drills were carried out and regular testing of fire and electrical equipment. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person.

The home was clean throughout without any odours present and had a pleasant homely atmosphere. Staff

had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. Staff had access to hand washing facilities and used gloves and aprons appropriately. There was a designated staff member to undertake laundry duties each day. The laundry was well managed and had adequate chemicals and processes to ensure the lint filters were cleaned regularly. Soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance.

Emergency systems were in place to protect people. There were individual personal evacuation plans which took account of people's abilities, the assistance they required, room location and equipment needed. These were held in people's care files and inside the fire book accessible to the fire services in the event of a fire emergency. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely.

The provider also had a business continuity plan in place. The plan contained emergency contact telephone numbers and guidance for staff in an emergency. They had also made reciprocal arrangements with other providers and a service under the same provider for a place of safety for people to go in the event of an evacuation being required. This showed the home had plans and procedures in place to safely deal with emergencies.

Accidents and incidents were reported in accordance with the organisation's policies and procedures. They were reviewed to identify ways to reduce risks as much as possible and relevant health professionals and relatives were informed.

Good

Is the service effective?

Our findings

People received care and support from staff that received training and support on how to undertake their role safely and effectively. The mandatory training staff completed included, conflict resolution, Control of Substances Hazardous to Health (COSHH), dementia, deprivation of liberties safeguards (DoLS), equality and diversity, fire safety at work, first aid, health and safety law, infection control, moving and handling, positive behaviour support and safeguarding vulnerable adults. Staff at the service had achieved 91percent compliance with the provider's required training. Staff were positive about the training they received. One care worker commented, "We do loads of training which is good." A health professional said, "Staff seem professional and competent in their dealings with residents."

The nurses at the service undertook additional training to ensure they had the knowledge and competence to undertake their role. This included medicines, fire warden training, safe use of bedrails and reporting of injuries, diseases and dangerous occurrences (RIDDOR). Checks were made by the registered manager to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK.

Induction training for new staff consisted of a period of 'shadowing' senior care workers to help them get to know the people using the service. New care workers who had no care qualifications, undertook the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice. One new care worker said, "We get to know them (people) by following a senior." A senior care worker said, "We mentor staff for about three shifts or a week, when they do shadow shifts. They are supernumerary; we show them the routines, doing personal care with the residents and show them how to care."

Staff confirmed they received supervision on a regular basis. Staff had supervision every two months and an annual appraisal. The registered manager said he would hold supervisions more regularly if staff needed additional support. Supervisions were carried out by senior staff. The registered manager undertook supervisions with the nurses and heads of department. They said he also did other staff when able, "It is not right that they only see me when something is wrong." Staff said they found the supervisions really useful and were positive about the support they received from their line managers. One care worker said senior staff were very supportive and the management were approachable. They explained they had progress reviews and regular supervisions to ensure they were settling in well, looked at their training needs and to check shift patterns were suitable for them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) and we found the home was meeting these requirements.

Although there were keypads on doors throughout the home people who were able could have the codes and leave if they were able. One care worker said that only a couple of people had the physical ability to leave without requiring assistance.

People confirmed they were always asked for their consent before care and support was provided. Where people were able, they had been requested to sign care records to confirm their consent. Where one person had not been able to sign staff had recorded that they had verbally agreed and had signed on their behalf. Where one person had been assessed as requiring pressure relieving equipment to protect their skin, staff had respected their wishes. They had recorded that the person had said they did not want the specialist mattress. We spoke with the person who confirmed this as their wish.

The registered manager and deputy had a clear understanding about the principles of the MCA. Staff had received training on the MCA and they demonstrated an understanding of people's right to make their own decisions. Staff had completed capacity assessments for people and considered people's capacity to make particular decisions. However, it was not always clear how best interest decisions had been made and who had been involved in the decision making process. The registered manager wrote to us following the inspection and confirmed they had reviewed 'best interest decisions' and ensured the appropriate information was recorded.

People had access to healthcare services for on going healthcare support. They were seen regularly by their local GP, and had regular health appointments such as with the dentist, optician, and chiropodist. People's care records contained the contact details of GPs and other health care professionals for staff to contact if there were concerns about a person's health. Staff worked with health professionals such as the community nurses, dietician, speech and language therapist (SALT), occupational therapists and physiotherapists. Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately. Comments included, "We are mainly called upon to provide assessment and advice around (health need) problems and this appears to be sought by them in a timely manner. Staff are generally efficient and helpful during my contacts and demonstrate a good awareness and reasonable knowledge of (health) problems and related issues" and "they called for advice appropriately, acted on our advice appropriately and cared for the patients well, safely and sensibly."

People were supported to eat and drink enough and maintain a balanced diet. The service had a four week rotating menu plan and people had a choice of two main meal options at lunchtime. When a new person came into the home, staff informed the cook about their likes, dislikes and meal requirements. There was also a white board in the kitchen where people's dietary requirements were recorded so all staff would be aware.

We observed a lunchtime meal in the dining room during our visit. There were 15 people using the dining room with others choosing to have theirs in their rooms or the dining room on the first floor. There was a pleasant atmosphere and people were interacting sociably with other people using the service. People had been asked the previous day for their meal choices and were having meals as they had chosen and were positive about the food. There was a picture menu board on the wall in both dining rooms to advise people of the meal choices each day. Some people were using plastic beakers while others had china cups. We were told by a care worker that this was because people preferred them because they had handles, were lighter and it was easier for people to grip.

Care workers were very attentive to people's needs, ensuring they had drinks. Some people were being supported with their meals. Care workers sat with these people and supported them without rushing and engaged in conversation. Where there were concerns about people's food and fluid intake, monitoring

charts were put into place. The fluid chart had a target of required fluids for each person, which was checked twice a day by senior staff to see if they were on target to achieve. The food diary was assessed each day to see if people had an adequate diet and recorded whether the person's food intake was 'good, average or poor'.

The majority of people praised the food at the service. Comments included, "Very good. I was asked yesterday what I would like for lunch today. We always start with soup.."; "Well treated here, food is usually good"; "Food really good, two choices a day, if I don't like something I say and you have a choice of what you do want"; "Brilliant absolutely … keep me informed … today is chips and bread and butter" and "Food good quantity and quality." One visitor said, "The food looks lovely, although my aunt eats little." Where one person was not happy with the variety of the food the cook was aware of this and was working with them to find alternatives.

One person who required a diabetic menu said they had a very limited choice regarding the desserts. We discussed this with the registered manager and cook that there was very little choice for people requiring a diabetic dessert. Following the inspection we were sent a newly devised diabetic dessert menu which had been put into place with a selection of appetising dessert which would be appropriate.

Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). Where the SALT had recommended soft or pureed food, each food was separately presented. Where the GP had prescribed a thickener to be put into people's drinks when they had difficulty swallowing. There was little guidance for staff regarding the consistency required for each person and how much thickener was required to achieve the required consistency. Following the inspection the registered manager wrote to us and said they had put, "easy fact sheets" for people who required their fluids to be thickened. This meant staff had the required guidance. Where people had been assessed as at risk of weight loss, they had their weight monitored regularly.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. We spent time talking with people and observing the interactions between them and staff. Staff were thoughtful, friendly and considerate towards people. People were seen positively interacting with staff, chatting, laughing and singing. People said they were happy at the home. One person commented, "They are most kind, they are lovely, I am very happy here. If I call they come quickly." A visitor said they were happy with the care their relative received and was always happy with how well presented they were.

Staff said they felt the care was good at the service. Comments included, "I have never seen anyone treated unkindly, we class them as family"; "My (family member) stayed here. I have faith in the girls, they have all got there heart and soul in here. A lovely place to work" and "Yes we do care for them, we give them choice."

Staff treated people with dignity and respect when helping them with daily living tasks. Staff said they maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering and gained consent before providing care. Comments included, "When we enter their room we make sure we knock on the door, offer choice with meals, when hoisting them we cover their legs with a blanket" and "I feed people individually… give them a lot of time, respect their wishes."

Staff treated people with kindness and compassion in everything they did. Throughout our visits staff were smiling and respectful in their manner. They greeted people with affection and by their preferred name and people responded positively. The atmosphere at the home was calm. During lunch care workers supported people eating their lunch in the dining room. They were discreet and not rushed in their approach and retained eye contact with the person throughout to give them reassurance.

Staff involved people in their care and supported them to make daily choices. For example, people chose the activities they liked to take part in and the clothes they wore. We observed a care worker attending to a person to see if they were ready to get up and dressed for the day. The person responded "not yet" and this was respected and the care worker returned later.

Staff described ways in which they tried to encourage people's independence such as dressing themselves with minimum support. Staff said they knew people's preferred routines, such as who liked to get up early and who liked to stay in bed. They ensured people were given a choice of where they wished to spend their time.

There were numerous messages of thanks which had been sent to the registered manager and staff. These included, "We really appreciate the quality of care here and the dedication on display every day. We have learned through watching you that real love still exists in this increasingly cruel and wicked world"; "I would like to thank you for taking such good care of dad during his short time with you. It is a comfort to us that we were able to be with him at the end…Thank you very much for your kind consideration and help in making the arrangements"; "Would like to thank everyone for the care, dedication, nursing given to (person)"; "I would like to thank you for the care and concern you showed to my mother (person) while she was with you.

You and your staff made her last few months as comfortable and safe as was possible in the circumstances".

People's relatives and friends were able to visit without being unnecessarily restricted. Visitors were made to feel welcome when they came to the home. People's rooms were personalised with their personal possessions, photographs and furniture.

People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, including the person's views about resuscitation in the event of unexpected illness or collapse.

Requires Improvement

Is the service responsive?

Our findings

People received personalised care that aimed to meet their individual needs. People confirmed the daily routines were flexible and they were able to make decisions about the times they got up and went to bed, how and where they spent their day and what activities they participated in. One person said, "I get on with everybody now. There was a bit of turbulence when I first came. I like things done my own way. They are now!" A visitor said, "We looked at several (care homes). We knew instantly it was very good. They are brilliant. The care is great, the staff are friendly."

Some people's individual needs had been identified by staff and were having those needs supported. But care plans reflecting those needs and guiding all staff to ensure consistency had not been put into place. For example for epilepsy and a person with a contracted hand. We discussed this with the registered manager who informed us after the inspection that they had undertaken a review with the deputy manager of everyone's care plans and where there were gaps care plans were put into place. They sent the Care Quality Commission (CQC) copies of care plans we had identified as needing improvement.

Support plans were held in a main file and files in people's rooms. The files also contained monitoring sheets and were where staff recorded support they had given. This meant that staff were able to have guidance regarding the individual support the person required. Where staff had made entries in the daily records they had only described care delivery and clinical tasks achieved. They had not been written in a person centred way to determine the person's views, mood, wishes and events of the day. We discussed this with the registered manager. After the inspection they sent us an email telling us, "this matter has been addressed straight away on the daily hand overs… will be discussed on upcoming planned supervisions and January monthly meeting, also the management will carry out random checks to make sure this area has improved and person centred daily notes continue a high level."

The service was responsive to people's needs because people's care and support was delivered in a way the person wished. Wherever possible a pre admission assessment of needs was completed prior to the person coming to the service. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. This information was used to develop care plans. The service used a form called 'This is me' (similar to the alzeimhers society form). They completed it with people to ascertain what they liked to eat and drink and how they wanted to be supported, activities they were interested in, communication need, moving around, 'my day' and important things you need to know.

Care files included personal information and identified the relevant people involved in people's care, such as their GP, optician and chiropodist. Care plans gave information about people's health and social care needs and showed that staff had involved other health and social care professionals when necessary. When necessary, referrals were made to the dietician and Speech and Language Therapist (SALT) recommendations were followed and incorporated within the care records. Risk assessments included an assessment of nutritional needs, mobility, falls and skin integrity. Nurses completed monthly reviews of people's risk assessments and care plan reviews of designated individual people's needs. Relevant

assessments were completed and up to date. Care plans had been reviewed in a timely way. People and their families were given the opportunity to be involved in reviewing their care plans.

People were supported to take part in social activities. A designated activity person was employed for 20 hours a week to undertake activities. They produced an activities sheet each week for people to be aware of the activities arranged. The week we visited these included: one to one sessions with people, film, songs of praise with a local organisation, musical bingo and a sing-along. They also dedicated time to visit people on a one to one basis who did not want to or were unable to, be involved in group activities. The activity person had recorded where people took part and where people had declined.

People had the opportunity to join in group activities. However there was no clear oversight which meant the registered manager was assured all people had the opportunity to partake in regular meaningful activities. Following the inspection the registered manager made us aware of a new system they had implemented which meant they could clearly see people's social interactions. People said they could take part in activities if they chose. Comments included, "If I wanted to I could and "They offer every day and keep me informed about what is going on."

External entertainers visited the home to entertain people. A Holy communion was held every other Wednesday and songs of praise alternate Wednesdays. People's birthdays and special celebrations were celebrated by the service. For example a birthday cake was supplied for people's birthdays. One relative had written to the registered manager saying, "Thank you all so much for making Mum's birthday so lovely with the cake etc."

People and their relatives knew how to share their experiences and raise a concern or complaint. People were happy they could raise a concern if they needed to and were confident the registered manager would listen and take action if required. People's comments included, "If I was concerned, I would speak to the carers or (deputy manager)"; "any of the carers would sort it out and my sons would say" and "If we had a problem we would go to (registered manager) he would sort it." Visitors said, "Excellent care no complaints at all. Can't find any fault" and "You can't beat this, you are made to feel welcome. No complaints… I could go to the manager and he would listen."

There was a complaints procedure displayed in the main corridor at the service. The procedure included information about the external agencies people could contact if they were not satisfied with the response from the service. There had been one complaint brought to the attention of the registered manager in 2016. They had thoroughly investigated the concern and taken action where required.

Good

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). People and their relatives were positive about the registered manager. They said they were approachable and always available if they wanted to talk with them. The registered manager was supported by a deputy manager. They undertook duties and were responsible for the oversight of people's clinical needs and day to day running of the service assisted by registered nurses and senior care workers. For example, they administered people's medicines, completed their care reviews and undertook any nursing requirements. Everyone had a clear understanding of their responsibilities and referred people appropriately to outside healthcare professionals when required. The staff knew each person's needs and were knowledgeable about their families and health professionals involved in their care.

The registered manager was supported by the provider's higher management team. A monthly quality assurance visit was carried out where the management team checked that the service was operating safely. They undertook a walk around the home, spoke with people, visitors and staff and ensured audits had been completed and that there were no outstanding actions from previous visits. The registered manager said they could ring their line manager at any time and they were very supportive. They undertook two visits a month to undertake a person development meeting with the registered manager. He could also contact the provider's 'Quality Compliance manager's for guidance when required. The registered manager attended an annual 'Providers meeting' organised by the local authority. They also had regular meetings with other managers in the provider's group to share ideas and learning.

There were accident and incident reporting systems in place at the service. The registered manager monitored and acted appropriately regarding untoward incidents. They checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns they took action to find ways so further incidents could be avoided. They also completed the provider's database with the information of accidents and incidents at the service. This enabled the provider's management team to be able to analyse trends to establish whether there were any patterns. Where a pattern was identified, actions were put in place to reduce the risk of recurrence.

The provider had a range of quality monitoring systems which were used to continually review and improve the service. These included an audit program which the registered manager completed with staff for medicines, care plan, pressure care and infection control. The registered manager also undertook audits they felt relevant to ensure the safe running of the service. These included laundry and kitchen, mattress and call bell response times, staff files and food and mealtime audits. The registered manager said as part of this audit they looked at the menus observed the mealtime experience and ensured people were being given choice. Where concerns had been found they had taken appropriate action for issues identified in the audits.

The registered manager undertook night and weekend spot checks to ensure good practice was maintained at all times. The service had an on call system which was shared by the registered manager and deputy

manager. This meant at all times staff were able to have someone they could contact if there were concerns at the service they were unsure how to deal with.

The provider held person centred care as a high priority at the service. They stated in 'the Provider Information Return' (PIR), "The company have "Our Values and Behaviours" which are discussed at team meetings and appraisals. These are also used in the selection process of new staff. The registered manager ensures that service users receive person centred care by: employing good staff, training them appropriately, and encouraging staff surveys, reviewing person centred support plans, observing the care given and undertaking daily walks around the home."

People and staff were actively involved in developing the service. A residents and relatives meeting was held twice a year. The last meeting held in June 2016 discussed the last survey results and the planned refurbishment. A meeting had been scheduled for the week of our visit. One visitor said, "They have meetings twice a year…we get sent the minutes. Communication is very good. We have nothing but praise, we have recommended it."

The provider commissioned an external company to send surveys to people. The registered manager said they were awaiting the results of the most recent survey to be collated. They confirmed when they received the results they would ensure people would see the results. He said he would share concerns and actions at the 'resident's meetings'. A questionnaire had been given to relatives and visitors in May 2016. They were asked about staff attitudes, presentation, knowledge, and cleanliness of the service. The results were positive and where there had feedback of concern the registered manager had responded to the relative.

Staff meetings were held every month. The registered manager also met with the registered nurses and housekeeping staff regularly to discuss issues specific to these roles. Records of these meetings showed staff were able to express their views, ideas and concerns. The record of the last staff meeting in December 2016 showed staff discussed, recruitment, new furniture and staff were reminded of the importance of health and safety and that issues should be reported. Staff were positive about the meetings. One care worker said, "We do get asked if we have any concerns."

Staff had a staff handover meeting at the changeover of each shift where key information about each person's care was shared any issues brought forward. This meant staff were kept up to date about people's changing needs and risks. We observed a handover and staff were all actively involved in the discussions and contributed, it was evident they knew people well.

In February 2016 the service was inspected by an environmental health officer to assess food hygiene and safety. The service scored four with the highest rating being five, which confirmed good standards and record keeping in relation to food hygiene had been maintained. Where concerns had been identified regarding missing tiles and damage to the floor action had been taken. The registered manager said they were just awaiting a stainless steel panel to be installed which had been ordered. The environmental health officer had recorded that "paperwork documentation was excellent."

The registered manager was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested.