Barchester Healthcare Homes Limited

Brook House

Inspection report

2-6 Forty Close
Forty Avenue, Wembley
London
HA9 8UU

Tel: 02089048371
Website: www.barchester.com

Date of inspection visit:
04 April 2016

Date of publication:
04 May 2016

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 4 April 20016 and was unannounced. Brook House is a care home with nursing. The home is owned and operated by Barchester Healthcare Homes Limited. Brook House is registered to provide care and accommodation for up to 47 people.

At our last inspection on 6 August 2014 the service met the regulations inspected.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (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.

People and their relatives informed us that they were satisfied with the care and services provided. On the day of our inspection we observed that people were well cared for and appropriately dressed. People who used the service said that they felt safe in the home and around staff. Relatives of people who used the service and care professionals we spoke with told us that they were confident that people were safe in the home.

Systems and processes were in place to help protect people from the risk of harm and staff demonstrated that they were aware of these. Staff had received training in safeguarding adults and knew how to recognise and report any concerns or allegations of abuse. Comprehensive risk assessments had been carried out and staff were aware of potential risks to people and how to protect people from harm.

People's care needs and potential risks to them were assessed. Staff prepared appropriate care plans to ensure that that people received safe and appropriate care. Their healthcare needs were closely monitored and attended to. Staff were caring and knowledgeable regarding the individual choices and preferences of people.

On the day of the inspection we observed that there were sufficient numbers of staff to meet people's individual care needs. Staff did not appear to be rushed and were able to complete their tasks. However some staff we spoke with told us that the staffing levels were inadequate and extra staff were needed as they were sometimes very busy. We raised this with management and they informed us that staffing levels were regularly reviewed depending on people's needs and occupancy levels.

Systems were in place to make sure people received their medicines safely. Arrangements were in place for the recording of medicines received into the home and for their storage, administration and disposal.

We found the premises were clean and tidy and there were no unpleasant odours. There was a record of essential inspections and maintenance carried out. The service had an Infection control policy and measures were in place for infection control.

Staff had been carefully recruited and provided with induction and training to enable them to care effectively for people. They had the necessary support, supervision and appraisals from management.

People's health and social care needs had been appropriately assessed. Care plans were person-centred, detailed and specific to each person and their needs. Care preferences were documented and staff we spoke with were aware of people's likes and dislikes. Identified risks associated with people's care had been assessed and plans were in place to minimise the potential risks to people. People told us that they received care, support and treatment when they required it. Care plans were reviewed monthly and were updated when people's needs changed.

Staff we spoke with had an understanding of the principles of the Mental Capacity Act (MCA 2005). Capacity to make specific decisions was recorded in people's care plans.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS ensure that an individual being deprived of their liberty is monitored and the reasons why they are being restricted is regularly reviewed to make sure it is still in the person's best interests. The home had made necessary applications for DoLS and we saw evidence that authorisations had been granted and some were awaiting approval.

There were suitable arrangements for the provision of food to ensure that people's dietary needs were met. People were mostly satisfied with the meals provided. Food looked appetising and was freshly prepared and presented well. Details of special diets people required either as a result of a clinical need or a cultural preference were clearly documented.

People and relatives spoke positively about the atmosphere in the home. Bedrooms had been personalised with people's belongings to assist people to feel at home.

People and relatives told us that there were sufficient activities available. On the day of the inspection we saw people taking part in "morning chats" discussing the news and board games. Activities for the week included bingo, manicures, a quiz and a jazz performer was scheduled to perform at the home.

Staff were informed of changes occurring within the home through daily staff meetings as well as quarterly staff meetings. Staff told us that they received up to date information and had an opportunity to share good practice and any concerns they had at these meetings.

The home had carried out an annual relatives and resident's satisfaction survey in 2015 and the results from the survey was positive.

There was a management structure in place with a team of nurses, care workers, kitchen and domestic staff, deputy manager and the registered manager. Staff told us that the morale within the home was good and that staff worked well with one another. Staff spoke positively about working at the home. They told us management was approachable and the service had an open and transparent culture. They said that they did not hesitate about bringing any concerns to the registered manager.

There was a comprehensive quality assurance policy which provided detailed information on the systems in place for the provider to obtain feedback about the care provided at the home. The service undertook a range of checks and audits of the quality of the service and took action to improve the service as a result. Relatives spoke positively about management in the home and staff. They said that the registered manager was approachable and willing to listen. Complaints had been appropriately responded to in accordance

with the service policy.

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 who used the service and relatives we spoke with said that they were confident the home was safe.

Staff were aware of different types of abuse and what steps they would take to protect people. Risks to people were identified and managed so that people were safe and their freedom supported and protected.

We saw that appropriate arrangements were in place in relation to the management and administration of medicines.

The home was clean and infection control measures were in place. There was a record of essential inspections and maintenance carried out.

Is the service effective?

Good

The service was effective. Staff had completed training to enable them to care for people effectively. Staff were supervised and felt well supported by their peers and the registered manager.

People were able to make their own choices and decisions. Staff and the registered manager were aware of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and the implications for people living in the home.

People were provided with choices of food and drink. People's nutrition was monitored and dietary needs were accounted for.

People had access to healthcare professionals to make sure they received appropriate care and treatment.

Is the service caring?

Good

The service was caring. We saw that people were treated with kindness and compassion when we observed staff interacting with people who used service. The atmosphere in the home was calm and relaxed.

People were treated with respect and dignity. Staff respected

people's privacy and dignity and were able to give examples of how they achieved this.

Wherever possible, people were involved in making decisions about their care. Care plans provided details about people's needs and preferences. Staff had a good understanding of people's care and support needs.

Is the service responsive?

Good

The service was responsive. Care plans were person-centred, detailed and specific to each person's individual needs. People's care preferences were noted in the care plans.

There were activities available to people. People and relatives spoke positively about the activities available.

A formal satisfaction survey had been carried out in 2015 and the results were positive.

The home had a complaints policy in place and there were procedures for receiving, handling and responding to comments and complaints.

Is the service well-led?

Good

The service was well led. People and relatives told us that the registered manager was approachable and they were satisfied with the management of the home.

The home had a clear management structure in place with a team of care workers, kitchen and domestic staff, deputy manager and the registered manager.

Staff were supported by the registered manager and told us they felt able to have open and transparent discussions with him.

The quality of the service was monitored and there were systems in place to make necessary improvements.

Brook House

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, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced inspection on 4 April 2016. The inspection team consisted of two inspectors, a pharmacist inspector and a nurse specialist advisor.

Before we visited the home we checked the information that we held about the service and the service provider including notifications about significant incidents affecting the safety and wellbeing of people who used the service.

The provider also completed a Provider Information Return (PIR). The PIR 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. The PIR also provides data about the organisation and service.

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing.

We reviewed ten care plans, six staff files, training records and records relating to the management of the service such as audits, policies and procedures. We spoke with nine people who used the service and nine relatives. We also spoke with the registered manager, regional director and twelve members of staff. We spoke with one care professional.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe in the home, they told us "yes" or nodded to indicate that they did. One person told us, "I am completely safe." Another person said, "We are ok. I feel secure here. The staff are careful with what they are doing." Relatives told us that they were confident that people were safe in the home and around care staff. One relative said, "It is very safe here. I have no concerns whatsoever." Another relative told us, "Yes it is very safe here." One care professional we spoke with told us that they did not have concerns in respect of people's safety in the home.

Staff had received training in safeguarding people. They were able to describe the process for identifying and reporting concerns and were able to give examples of types of abuse that may occur. They told us that if they saw something of concern they would report it to the registered manager or deputy manager. Staff were also aware that they could report their concerns to the local safeguarding authority, police and the CQC. The home had a safeguarding policy and staff had details of the local safeguarding team and knew how to contact them if needed. However the policy still had reference to the Independent Safeguarding Authority and did not mention the requirement to notify the Care Quality Commission of allegations of abuse. We discussed this with the registered manager and regional director and they confirmed that the policy was currently being reviewed and would be updated.

The service had a whistleblowing policy and contact numbers to report issues were available. Staff were familiar with the whistleblowing procedure and were confident about raising concerns about any poor practices witnessed.

People's care needs had been carefully assessed. Care plans we reviewed included relevant risk assessments, such as the Malnutrition Universal Screening Tool (MUST) risk assessment, used to assess people with a history of weight loss or poor appetite. Pressure ulcer risk assessments included the use of the Waterlow scoring tool and falls risk assessment. One person had experienced three falls since the beginning of the year. We noted that there was a falls management plan in this person's care record and the falls had been monitored. It was evident that the service had identified individual risks to people and put actions in place to reduce the risks. These included preventative actions that needed to be taken to minimise risks as well as measures for staff on how to support people safely. Risk assessments were reviewed monthly and we saw documented evidence that these were updated when there was a change in a person's condition.

As part of the inspection we looked at how skin integrity of people who used the service was managed. We saw evidence that those people who had been assessed to be at high risk of developing pressure ulcers based on their Waterlow risk assessment, had measures in place to prevent them from developing pressure ulcers. People who were at high risk were provided with alternating pressure relieving air mattresses with functioning profiling beds. There were accurate records of repositioning charts during the day and night. These charts were kept and maintained for people at high risk of developing pressure ulcers. We found that air mattresses were set correctly and according to people's weight. We however noted that one person's mattress had a sticker stating that the last service due date was 24 February 2014 and we raised this with the registered manager. He confirmed that the label had not been removed and this had been an oversight. He

confirmed that the new correct label was on the cable of the mattress.

We looked at the staff rota and discussed staffing levels with the registered manager and regional director. On the day of inspection there were a total of 46 people who used the service. The staffing levels normally consisted of the registered manager, deputy manager and a nurse on each of three floors supported by ten care workers during the morning shift and seven care workers during the afternoon shift. During the night shifts there were two nurses and four care workers. In addition, the home had kitchen and other household staff. On the day of the inspection the atmosphere was calm in the home and staff were not rushed. We activated the call bell in one person's room during the inspection. The buzzer was responded to within 1 minute.

We spoke with staff about staffing levels in the home. Four care workers told us that that the staffing levels were inadequate and extra staff were needed as they were sometimes very busy. Two relatives also stated that the staffing levels were inadequate although staff did respond promptly when assistance was needed. This was discussed with the registered manager and regional director. We were informed that the staffing levels had been reviewed using the organisation's staffing tool and the home had sufficient staff deployed to meet the needs of people. They agreed to review the staffing levels again with staff to ensure there was sufficient staff.

Relatives told us there was consistency in terms of staff so that people who used the service were familiar with staff. This was evident through our observations. We saw that people who used the service were comfortable around staff.

We looked at the recruitment process to see if the required checks had been carried out before staff started working at home. We looked at the recruitment records and found comprehensive background checks for safer recruitment including enhanced criminal record checks had been undertaken and proof of their identity and right to work in the United Kingdom had also been obtained. Two written references had been obtained for staff.

The fire alarm was tested weekly to ensure it was in working condition. The last fire drill was carried out on 12 March 2016. The maintenance staff we spoke with confirmed that a night fire drill would be scheduled soon. The home had a fire risk assessment and a general evacuation plan. Personal emergency and evacuation plans (PEEP) had been prepared. However, these did not contain all required information. The registered manager stated that these would be updated.

The service followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the supplying pharmacy and the provider, including safe storage of medicines, room and fridge temperatures and stock quantities on a daily basis. When asked, the registered manager stated that no medicines incidents/ near misses had been reported recently. However, they demonstrated the correct process verbally of what to do should an incident/near miss arise in the future (including who to contact). This was in-line with their policy.

People received their medicines as prescribed, including controlled drugs. We looked at 16 Medicines Administration Records (MAR) and found a few gaps in the recording of medicines administered. These were picked up by weekly audits undertaken by the service and resolved appropriately. Also, we found that for medicines that required variable dosing, the exact dose given to people were not recorded on the MAR consistently. People told us they received their medicines in a timely and correct manner. Medicines were stored and locked away appropriately in the treatment rooms. The disposal of medicines were placed in the

appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Room and fridge temperatures were audited on a daily basis and in-range, and controlled drugs were appropriately stored in accordance with legal requirements, with weekly audits of quantities done by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them, even though there were some discrepancies in the documenting of these protocols. For example, we saw that one person's laxative and pain relief protocol had not been documented. People's behaviours were not controlled by excessive or inappropriate use of medicines. For example, we saw 12 PRN forms for pain-relief/laxative medicines. There were appropriate, up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit.

The registered manager confirmed he was happy with the arrangement with the supplying community pharmacy and GP, and felt that the service received appropriate support with regards to the training of nursing staff of high risk medicines (such as warfarin) and medicine reviews. This was evidenced by checking the record of a medicines review that had been carried out within the last six months. The registered manager confirmed that at least one GP came regularly to review people.

There was a record of essential maintenance carried out. These included safety inspections of the portable appliances, portable hoists, lifts, gas boiler and electrical installations. The hot water temperatures had been checked weekly and recorded. We spoke with one maintenance staff and he stated that he was aware of the importance of ensuring that hot water temperatures in the bathrooms and bedrooms were no higher than 43 degrees centigrade (C). We tested the water with their thermometer and noted that it was no higher than 43C. The registered manager stated that staff recorded the temperatures of the hot water prior to people having a shower or bath and this was recorded and we saw evidence of this.

The premises were well-maintained, clean and there were no unpleasant odours. There was an infection control policy and measures were in place for infection prevention and control. However we noted that the policy did not contain guidance on the management of MRSA (Meticillin resistant staphylococcus aureus) or details of the Health Protection Unit. Following the inspection, the registered manager explained that guidance regarding MRSA was included in the health and safety policy and sent us evidence of this. The registered manager told us that the details of the Health Protection Unit would be included in the infection control policy.

A cleaning schedule was in place which allocated cleaning responsibilities to staff to ensure that the home was kept clean and regularly monitored. Staff we spoke with had access to protective clothing including disposable gloves and aprons. We observed that soiled pads and linen were disposed appropriately, soiled linen in a red bag and pads in a yellow bag.

Good

Is the service effective?

Our findings

People who used the service and relatives indicated that they were satisfied with the care provided at the home. One person told us, "I am very happy here. I am looked after quite well. "One relative told us, "It is absolutely brilliant here. It is a very pleasant place to be. Carers are brilliant and caring." Another relative said, "Staff are good. They are warm and welcoming."

People had their healthcare needs closely monitored. Care records of people were well maintained and contained important information regarding medical conditions, behaviour and any allergies people may have. There was evidence of recent appointments with healthcare professionals such as people's dentist, optician and GP. Information following visits by GP and other professionals were documented in people's records.

Care records showed that nutritional needs of the people who used the service were met. Where people had a low weight and a low body mass index, we saw that the service had referred them to the dietician or GP for advice and were monitoring their progress. People's weights were recorded monthly so that the service was able to monitor people's nutrition and there was detailed information about people's nutritional needs. In one care plan we noted that it was recorded that this person had "a significant weight loss over the past few months", a MUST was recorded and it was documented that this person was at medium risk of malnutrition. There was detailed information included in the care plan about this person's nutrition requirements. It stated that this person "must be encouraged with pureed snacks between meals for example yoghurts, mousses and custard along with food fortification and extras such as butter, cheese and cream to all meals and snacks, encourage fluid intake and thickened water can be made more palatable with flavoured squash". There was a dietetic referral and the catering form included the person's likes and dislikes.

We saw that fluid and food charts were kept for people to record people's food and fluid intake. However we noted that out of five people's charts we looked at, two of these had an error in the recording of people's oral intake. For example, in one person's care plan it stated that this person was to have an oral intake of at least 1.5 litres. On the 3 April 2016 this person had an intake of 845mls, however there was an error in the recording where 585mls was documented. There were records of urinary output at 07:00 and 09:20 and nil recorded until 04:41 the following morning. On 2 April 2016 the fluid intake was incorrectly totalled and there was only one record of urine output at 13:00. Urine output was not always totalled and therefore fluid balance could not be calculated. In another person's care plan we noted that there was an incorrect totalling of fluid intake by 250mls on 26 March 2016. However this person did have a good oral fluid and food intake. We spoke with the registered manager and the regional director about these inconsistencies and errors and they confirmed that they would look into these.

Staff had the necessary equipment to manage people's needs. For instance, there were hoists available and they were in good working order. There were slings for different sizes used for people.

Staff had the knowledge and skills to enable them to support people effectively. We saw evidence that staff had undertaken an induction when they started working at the service. There was on-going training to

ensure that staff had the skills and knowledge to effectively meet people's needs. Training records showed that staff had completed training in areas that helped them to meet people's needs. Topics included safeguarding, medicines, first aid, fire training, infection control and food safety. Staff spoke positively about the training they had received and were able to explain what they had covered during the training sessions.

There was evidence that staff had received regular supervision sessions and this was confirmed by staff we spoke with. Supervision sessions enabled staff to discuss their personal development objectives and goals. We also saw evidence that staff had received an annual appraisal about their individual performance and had an opportunity to review their personal development and progress.

Staff told us that they felt supported by their colleagues and management. They were positive about working at the home. They commented on the good team spirit amongst staff, good knowledge and skills possessed by all staff in the home which had helped to maintained a good working standard in the home.

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.

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. We noted that care plans contained mental capacity assessments including information about people's mental state and cognition. Staff had knowledge of the MCA and training records confirmed that the majority of staff had received training in this area. Staff were aware that when a person lacked the capacity to make a specific decision, people's families, staff and others including health and social care professionals would be involved in making a decision in the person's best interests.

We also found that, where people were unable to leave the home because they would not be safe leaving on their own, the home had made applications for the relevant authorisations called Deprivation of Liberty Safeguards (DoLS). We noted that the service had made necessary applications and some authorisations were in place and some were awaiting approval which the registered manager was fully aware of.

The arrangements for the provision of meals were satisfactory. The majority of people spoke positively about the food. One person said, "The chef offers us a choice of meals." One person however told us, "The food could be more attractive." Relatives spoke highly about the food. One relative told us, "The food is first class. It is always good." Another relative said, "The food has always been fine. It is good." One relative we spoke with told us that there could be more options of food for people on a soft food diet. We raised this with the registered manager and he confirmed that this would be looked into.

During the inspection we spoke with the head chef about the food prepared in the home. He was knowledgeable of people's dietary needs and preferences and told us that all the food prepared in the home was freshly prepared daily. The home had a weekly menu and it included a variety of different types of foods. There were alternatives for people to choose from if they did not want to eat what was on the menu. During the inspection we observed people having their breakfast and lunch, which was unhurried. The atmosphere during breakfast and lunch was relaxed. Dining tables were laid attractively and people sat at tables with one another and were able to engage with staff and people who use the service. We observed that meals were presented attractively. Staff took care to offer people choices about what they wanted.

People were offered water, juice and teas and coffees during the meal. Staff were attentive and created a pleasant atmosphere chatting with people over lunch. We saw that people who were supported to eat were helped in a respectful manner with staff sitting next to them, and taking the time required to help them to eat. We saw that people were able to eat in their own rooms if they preferred and there seemed to be enough staff available to support people in their rooms as required.

The kitchen was clean and we noted that there were sufficient quantities of food available. We checked a sample of food stored in the kitchen and found that food was stored safely and was still within the expiry date. Food in packaging that had been opened was appropriately labelled with the date it was opened so that staff were able to ensure food was suitable for consumption.

People receiving end of life care had the appropriate plans in place. They also had "Do not attempt cardiopulmonary resuscitation" (DNACPR) forms in place. All the DNACPR forms we viewed were signed by the GP, relatives and nursing staff and were up to date. There were also care plans in place which clearly stated the end of life wishes for people.

Good

Is the service caring?

Our findings

People told us that they were well cared for in the home and that they were treated with respect. One person said, "Staff are very caring and helpful." Another person told us, "I don't think it could be better here. Staff are nice. They are happy and polite." Relatives told us that they were confident that people were well cared for in the home. One relative told us, "Staff are very very nice and always willing and they listen." Another relative said, "Staff having a caring attitude." Another relative told us, "There is nothing that could be done better." Another relative said, "It feels like a home, rather than an artificial place."

One care professional told us that they were confident that people were well cared for in the home and said that they had no concerns regarding this.

Staff we spoke with had a good understanding of the importance of treating people as individuals and respecting their dignity. They also understood what privacy and dignity meant in relation to supporting people with personal care. One member of staff told us, "I always ask people what they would like. It is their choice. I always make sure I spend time with people." We saw staff knocked on people's bedroom doors and waited for the person to respond before entering. Bedroom and bathroom doors were closed when staff supported people with their personal care needs.

We observed respectful and caring interactions between care staff and people who used the service. Care staff showed interest in people and were constantly present to ensure that people were alright and their needs attended to. We observed one person was unhappy with the colour of her nail polish and appeared agitated by this. A member of staff then asked this person if they wanted the nail polish removed and got nail polish remover and helped the person remove the nail polish. Staff were attentive and talked in a gentle and pleasant manner to people. Care staff smiled and asked people how they were. People responded by either smiling or nodding. People appeared to feel comfortable and at ease in the presence of staff.

We saw some detailed information in people's care plans about their life history and their interests. However we noted that this was not consistent in each file we looked at. We spoke with the registered manager about this and they advised that they would ensure all care plans included such information. Staff could provide us with information regarding people's background, interests and needs. This ensured that staff were able to understand and interact with people.

People were supported to maintain relationships with family and friends. Relatives told us that they were well treated whenever they visited the home and they were kept informed about their family member's progress. One relative told us, "I am kept informed of developments. I know what is going on." Another relative said, "They tell me what's going on."

Care plans included information that showed people had been consulted about their individual needs including their spiritual and cultural needs. Each care plan included a cultural, spiritual and social values section. The registered manager and relatives told us representatives of various faiths and denomination visited the home on a regular basis to support people with their spiritual needs and we observed this on the

day of the inspection. The home had a policy on ensuring equality and valuing diversity and staff had received training in ensuring equality and valuing diversity. They informed us that they knew that all people should be treated with respect and dignity regardless of their background and personal circumstances. Kitchen staff informed us that they were fully aware of people's cultural meal requests and we saw that this information had been documented. Halal and Kosher meals were provided for some people who used the service.

People had the use of a quiet lounge on each floor which was comfortable and inviting. People and relatives told us that they were satisfied with the home and that it had a "homely" feel. People had free movement around the home and could choose where to sit and spend their recreational time. We saw people were able to spend time the way they wanted. Some people chose to spend time in the communal lounges and some people chose to spend time in their bedroom.

The registered manager explained to us that they operated a system within the home which aimed to ensure that all people avoided social isolation. The system ensured that all people had some form of social interaction on a daily basis and a record was kept of this. He explained that this helped people feel involved in the running of the home.

All bedrooms were for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as photographs and ornaments, to assist people to feel at home.

Equipment such as hoists, grab rails and air mattresses had been provided to assist those with mobility difficulties.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. Care plans were up to date and had been evaluated by staff and reviewed with people, their relatives and professionals involved. This provided staff with current guidance on meeting the needs of people. Staff we spoke with explained to us that they respected the choices people made regarding their daily routine and activities they wanted to engage in.

Good

Is the service responsive?

Our findings

People who used the service and relatives told us they were happy to raise any concerns they had with the staff and management at the home. One person said, "I don't need to complain but if I had to I would." Another person told us that they were aware of the complaints procedure and would speak with the manager if they had to. This person said, "They listen and respond." One relative said, "I feel able to raise queries if I have to. I have no hesitation."

There was a complaints policy which was displayed throughout the home. There were procedures for receiving, handling and responding to comments and complaints. We saw the policy also made reference to contacting the CQC if people felt their complaints had not been handled appropriately by the home. The service had a system for recording complaints and we observed that complaints had been dealt with appropriately in accordance with their policy.

Meetings were held quarterly for people living at the home as well as relatives where they could give their views on how the home was run. People and relatives we spoke with confirmed that they could attend these meetings if they wished to do so. One relative told us, "I go to the meetings. I feel able to bring up issues if I need to."

The service provided care which was individualised and person-centred. People and their representatives were involved in planning care and support provided. People's needs had been carefully assessed before they moved into the home. These assessments included information about a range of needs including health, social, care, mobility, medical, religious and communication needs. Care plans were prepared with the involvement of people and their representatives and were personalised. Staff had been given guidance on how to meet people's needs and when asked they demonstrated a good understanding of the needs of each person.

Care plans were reviewed monthly by staff and were updated when people's needs changed. The registered manager explained that the regular reviews enabled staff to keep up to date with people's changing needs and ensured that such information was communicated with all staff.

People who used the service and relatives we spoke with told us there were activities available for them to participate in. They spoke positively about the activities available. The home employed three activities co-ordinators and we noted that there was some form of activity available every day during the week. On the day of inspection we observed people taking part in "morning chats" discussing the news and board games. Activities for the week included bingo, manicures, a quiz and a jazz performer was scheduled to perform at the home. An activities co-ordinator we spoke with told us that the home held garden parties, cinema showings and had also arranged for an owl to visit the home which was very popular amongst people in the home.

The registered manager explained to us that it was important to ensure that people felt able to raise their concerns and issues and had an opportunity to voice their opinion. The home carried out an annual relative

and resident's satisfaction survey in 2015 and the results from the survey was positive. The survey found that 100% of people who use the service felt that they were treated with kindness, dignity and respect. The survey also found that 100% of people found that staff have a professional manner.

Good

Is the service well-led?

Our findings

People and relatives expressed confidence in the management of the home. One person said, "The manager is very nice." One relative told us, "The manager is extremely helpful and genuine. He always helps and acts immediately. I can go to him no matter what." Another relative said, "The manager is always available. He is very much on the floor and very present in the home." Another relative told us, "The manager is very nice. He is always around."

One care professional we spoke with stated that the home maintained good liaison with them and communication was good.

There was a management structure in place with a team of nurses, care workers, kitchen and domestic staff, the deputy manager and the registered manager. Staff had a positive attitude and were of the opinion that the service was well managed and the registered manager was supportive and approachable. They indicated to us that morale was good and they had received guidance regarding their roles and responsibilities. One member of staff told us, "The manager is good. He has a heart of gold. I received really good support here and enjoy working here." Another member of staff said, "We have a very good manager. I feel supported. He helps solve issues and listens." Staff were aware of the values and aims of the service and this included treating people with respect and dignity and providing a high quality service.

The service had a system for ensuring effective communication among staff and this was confirmed by staff we spoke with. Staff informed us that there were daily "stand up" meetings where they could discuss the care of people and any specific issues on a daily basis. We also saw evidence that there were quarterly staff meetings where staff received up to date information and had an opportunity to share good practice and any other concerns.

Care documentation was up to date and comprehensive. The home had a range of policies and procedures to ensure that staff were provided with appropriate guidance to meet the needs of people. These addressed topics such as infection control, safeguarding and health and safety. Staff were aware of these policies and procedures and followed them. People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential.

Accidents and incidents were recorded and analysed to prevent them reoccurring and to encourage staff and management to learn from these.

There was a comprehensive quality assurance policy which provided detailed information on the systems in place for the provider to obtain feedback about the care provided at the home. The service undertook a range of checks and audits of the quality of the service and took action to improve the service as a result. We saw evidence that regular audits and checks had been carried at regular intervals in areas such as care documentation, health and safety, equipment, cleanliness of the home, medicines and staff training. We saw evidence that management carried out unannounced observations around the home to ensure that the home was running efficiently. A weekly meeting of the heads of department took place each week so that

the registered manager was kept informed of any issues which may affect the care of people.