Anchor Trust

Elderwood Residential Home

Inspection report

Westmoreland Street
Darlington
DL3 0FB
Tel: 01325 368256
Website: www.anchor.org.uk

Date of inspection visit: 13 and 14 May 2015
Date of publication: 07/08/2015

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

Overall summary

This inspection took place on 13 and 14 May 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

Elderwood Residential Home provides care and accommodation for up to 40 older people and people with a dementia type illness. On the day of our inspection there were 36 people using the service.

The home had a registered manager in place. 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. During our visit the registered manager was on sick leave and the care manager was in charge of the home.

Elderwood Residential Home was last inspected by CQC on 8 August 2013 and was compliant.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Summary of findings

Thorough investigations had been carried out in response to safeguarding incidents or allegations and comprehensive medicine audits were carried out regularly by the care manager.

Staff training was up to date and staff received regular supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

The home was clean, spacious and suitable for the people who used the service.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We discussed DoLS with the care manager and looked at records. We found the provider was following the requirements in the DoLS.

We saw people had given consent to their care and treatment.

People who used the service, and family members, were complimentary about the standard of care at Elderwood Residential Home.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

We saw that the home had a full programme of activities in place for people who used the service.

Care records showed that people's needs were assessed before they moved into Elderwood Residential Home and care plans were written in a person centred way.

The provider had a complaints policy and procedure in place and complaints were fully investigated.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. There were sufficient numbers of staff on duty in order to meet the needs of people using the service and the provider had an effective recruitment and selection procedure in place. Thorough investigations had been carried out in response to safeguarding incidents or allegations. Comprehensive medicine audits were carried out regularly by the care manager.	**Good**
Is the service effective? The service was effective. Staff training was up to date and staff received regular supervisions and appraisals. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People had given consent to their care and treatment.	**Good**
Is the service caring? The service was caring. Staff treated people with dignity and respect. People were encouraged to be independent and care for themselves where possible. People were well presented and staff talked with people in a polite and respectful manner. People had been involved in writing their care plans and their wishes were taken into consideration.	**Good**
Is the service responsive? The service was responsive. Risk assessments were in place where required. The home had a full programme of activities in place for people who used the service. The provider had a complaints policy and complaints were fully investigated. People who used the service knew how to make a complaint.	**Good**
Is the service well-led? The service was well led. The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources. Staff told us the registered manager was approachable and they felt supported in their role.	**Good**

Elderwood 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.

This inspection took place on 13 and 14 May 2015 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector, a specialist advisor in nursing and an expert by experience took part in this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff and district nurses. No concerns were raised by any of these professionals.

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.

During our inspection we spoke with 14 people who used the service and six family members or friends. We also spoke with the care manager (the registered manager was on sick leave), district manager, five members of staff and four visiting health care professionals.

We looked at the personal care or treatment records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff.

Good

Is the service safe?

Our findings

Family members we spoke with told us they felt very secure in the knowledge that their relatives were in good hands at the home. One visitor told us, "The carers communicate with me regarding my father's needs and I am very satisfied. My Dad is happy here" and "He is safe".

We looked at the recruitment records for three members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

The care manager explained the staffing rotas to us and we saw there was one or two team leaders on duty at all times during the day, with two care staff on each floor. Night staffing consisted of one team leader and two care staff. The home also employed an activities co-ordinator five days per week, an administrative member of staff, two domestic staff, three kitchen staff, a maintenance member of staff and a member of staff in the laundry room. We observed sufficient numbers of staff on duty and call bells were answered promptly.

We saw that entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, spacious and suitable for the people who used the service. The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. Corridors were spacious and bedrooms were large and had en-suite facilities. In the rooms we looked in we saw window restrictors were fitted, which looked to be in good condition, and wardrobes were secured to walls. Refurbishment work was being carried out during our visit, which included the en-suite facilities in 20 bedrooms being renewed and new footpaths being laid in the gardens.

The home was clean and no offensive odours were present. We saw an infection control audit had been carried out by the infection control team on 10 December 2014. We spoke with the nurse who carried out the audit and they told us they had no concerns and had not identified any risks in the home.

We looked at the 'Health and safety checks' folder and saw the 'Home manager monthly safety checklist', which had been completed up to April 2015. This included checks of hazardous substances, accident and incident monitoring, fire safety, bed rails and we saw that actions from the monthly health and safety meeting had been carried out. We also saw monthly moving and handling checks were carried out, including checks of equipment and weekly health and safety checks of doors, gates, alarm systems, lifts and the kitchen had been carried out and were up to date.

We saw maintenance and service records were up to date and included electrical installation, gas safety, water system/legionella certificate, portable appliance testing (PAT) and hot water temperature checks.

The service had a business continuity plan and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We looked at the safeguarding file and saw records of safeguarding incidents and saw that CQC had been notified of relevant incidents. We saw the accidents and incidents file and saw that information on every accident or incident in the home was recorded on the provider's accident and incident forms. These included when and where the accident/incident took place, who was involved, details of the person completing the form, details of the accident/incident, the severity and category of accident/incident, whether it was reported to external agencies and lessons to be learned. We asked the care manager and district manager whether any analysis was carried out into accidents/incidents in the home. They told us all the accidents/incidents were inputted on to the provider's electronic system and analysis was carried out to identify any trends.

Good

Is the service safe?

We asked staff how comfortable they felt about raising concerns. They told us, “I’d go straight to tell them, what you see is what you get” and “I did and we got two drug rooms and one trolley upstairs and one downstairs”.

We looked at the management of medicines. We found that the service had up to date policies and procedures in place, which were regularly reviewed, to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. The care manager told us that they and a senior member of the care staff conducted six monthly observations to assess staff’s competency when dealing with medicines. These measures ensured that staff consistently managed medicines in a safe way, making sure that people who used the service received their medicines as prescribed.

We saw one person self-administered their medicines. Staff told us they monitored the administration of medicines to ensure the person was safe and showed us the ‘Self-administration monitoring form’ that they completed on a weekly basis. Medicines for self-administration were stored in a lockable cabinet in the person’s room; to enable them to access their medicines when they need to use them.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs (CD), which are medicines which may be at risk of misuse. Controlled drugs were stored in a separate locked CD cabinet, which was solely used for the storage of CDs. We saw that care staff, who had authorised access, held the keys to the CD cupboard.

We saw people receive their medicines at the time they needed them. We saw care staff checked people’s medicines on the MAR chart and medicine label, prior to supporting them, to ensure they were getting the correct medicines and we observed care staff remain with each person to ensure they had swallowed their medicines and sign the MAR after administration.

Medicines requiring cool storage were kept in a fridge which was locked. We saw that temperatures relating to refrigeration had been recorded daily and were between two and eight degrees centigrade. We saw that temperatures for the treatment room were recorded daily and they were less than 25 degrees centigrade.

The care manager told us that they were responsible for conducting weekly medicines audits, including the MAR charts, to check that medicines were being administered safely and appropriately.

Good

Is the service effective?

Our findings

People who lived at Elderwood Residential Home received effective care and support from well trained and well supported staff. One person told us, “I am waited on hand and foot. I have everything I want. This place is wonderful and the staff are so good to me.” Another person told us, “If I need anything I just ask the staff and they get it.” The person’s daughter told us, “I have no concerns. I am happy about the care my Mum receives here”.

We saw a copy of the provider’s electronic training matrix, which was colour coded to show when training was completed, due or overdue. We saw training was broken down into ‘Statutory’, which all members of staff had to complete, and ‘Mandatory’, which was role specific. Statutory training included an induction to the provider and the home, fire safety, food safety, health and safety, mental capacity, safeguarding and care planning. We saw from the training matrix that 99% of mandatory training was complete and 100% of statutory training was complete. Each member of staff had an ‘Employee passport’, which was a training record and included the name of the training course taken, type of training, the date of the training and when the training expired. We checked staff files and saw certificates for training courses completed were held for each member of staff.

Staff we spoke with told us they had undergone a lot of training, particularly in dementia care, safeguarding and moving and handling. They told us, “I’ve done loads of training, palliative care, I learn every day. I learnt about movements on the emergency evacuation training. The care manager does my medication competency twice yearly”.

We saw a copy of the supervisions and appraisals planner and saw that supervisions were planned every two months, with an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. All staff apart from those on maternity leave or long term sick had received an appraisal between January and April 2015. We saw records of staff supervisions, which had been completed approximately every two months, and included a review of roles and responsibilities and training requirements. We asked staff about supervisions and how often they had them. They told us, “Six weekly, we discuss training, values and behaviours, timekeeping, the rota, roles/responsibilities, problems and anything else we want to talk about.”

We observed lunch being served to 16 residents in the downstairs dining room. The staff were very attentive to all the people’s needs. Each person was shown the choices and allowed to decide which they wanted. Everyone we saw was able to feed themselves. People told us, “The food is very good. I love it” and “The food is good. I especially like the dinners”. A visitor told us, “My aunt has put on weight since she came in here. She enjoys the food so much”. All of the people we spoke with praised the cooking and high standard of food they received. One person, who told us she had been a very skilled cook said, “I like the food they give you in here. It is very good.”

We saw the home had a four week menu, with two options at lunch time and alternative meal choices available. A light evening meal was offered, which included soup, jacket potatoes, and toast, and supper items were available if people required them.

Malnutrition Universal Screening Tool (MUST) risk assessments were used to identify specific risks associated with people’s nutrition. These assessments were reviewed on a monthly basis. Where people were identified as being at risk of malnutrition, referrals had been made to the dietitian and speech and language therapist (SALT) for specialist advice. Choking risk assessments were used to identify specific risks associated with people’s eating and drinking and we saw people were weighed in accordance with the frequency determined by the MUST score, to determine if they were at risk of malnutrition. We also saw care plans contained information on people’s dietary needs and the level of support they needed to ensure they received a balanced diet.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We discussed DoLS with the care manager and saw the ‘DoLS information file’. We saw that 16 DoLS had been requested since August 2014 however three had

Good

Is the service effective?

been rejected and eight were still waiting to be authorised. We also saw evidence that notifications of the authorisations had been submitted to CQC. This meant the provider was following the requirements in the DoLS.

We saw a copy of the provider's 'Consent to care and treatment' policy. Which included details of what to do if a person lacked capacity and what to do if consent was refused or withdrawn. We saw the 'Media consent forms file' which included copies of signed consent forms that people who used the service had been asked to sign to give permission for their photograph to be used for publicity and promotions. If the person lacked capacity, there was a section of the form for their representative to sign. Consent to care and treatment records were included in care files and we saw mental capacity assessment records provided evidence that, where necessary, assessment had been undertaken of people's capacity to make particular decisions. This meant that the person's rights to make particular decisions had been protected, as unnecessary restrictions had not been placed on them.

Do not attempt cardiopulmonary resuscitation (DNACPR) forms were included for one person and we saw evidence that the person, care staff, relatives and healthcare professionals had been involved in the decision making. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). We also saw end of life care plans were in place for people, as appropriate.

We spoke with visitors regarding communication with the staff. All said they were advised quickly of any health problems. One visitor told us, "I have no concerns regarding my mother's care in here. It is so good. The staff spoil her by the attention they give her." A person who used the service told us she had damaged her foot recently and that the staff had taken her to the accident and emergency ward at the local hospital.

We saw records of health care professionals involved in people's care, including visits to the home by General Practitioner (GP), community matron, district nurse, anti-coagulant nurse and chiropodist. This meant that people received ongoing healthcare when they needed it and were supported to maintain their health.

We saw signage around the home was appropriate, however not specific for people with dementia. Numbers, and in some cases names, were on people's bedroom doors and bathrooms and toilets were clearly marked. Corridors were clear from obstructions and well lit, which helped to aid people's orientation around the home. The care manager showed us an area on the first floor landing that was being converted into an indoor garden for people to use. This project was agreed following "dementia inspires" training for seven members of staff. The care manager told us other plans were in place to make the home more dementia friendly, including wall art.

Good

Is the service caring?

Our findings

People who used the service were complimentary about the standard of care at Elderwood Residential Home. They told us, “I am very happy here. If I want anything, the staff attend to it for me”, “They really look after me well”, “We like it here, they look after us here” and “This place is great. The staff are brilliant. They care for me well”. The care manager told us she travelled one hour each day to get to work and said, “I wouldn’t want to work anywhere else. It’s a lovely home.”

People we saw were clean and appropriately dressed. We saw staff talking to people in a polite and respectful manner and were attentive to people’s needs. Staff were seen chatting on a one to one basis with people and responding to people with understanding and compassion. We saw the care plan for one person detailed the following, “Staff to listen to [Name] and give them time if not able to find words. Staff to communicate in normal tone and not shout. Staff to ensure glasses are clean and worn”.

We saw evidence of very friendly exchanges between staff and people who used the service, all on first name terms. One person told us, “The staff are brilliant and they care. They care for me well.” We saw people were asked what they wanted to do and staff listened. People appeared comfortable in the presence of staff.

We saw care staff assist people when required and care interventions were discreet when they needed to be. We saw the care manager discretely adjust a person’s hearing aid to enable them to be involved in a conversation and ask a member of staff , “Will you get [Name] a cup of tea please?”

We observed that staff were respectful when talking with people, calling them by their preferred names. We observed staff knocking on doors and waiting before entering. This meant that staff respected people’s privacy and dignity.

We observed that quite a few people liked to be out in the communal areas while others preferred the privacy of their rooms. We saw people were supported to maintain their independence and care staff told us people were supported to participate in activities, for example, the Grand National and Easter egg decoration activities. We observed staff regularly asking people if they needed anything and offering choices such as whether they wanted to go back to their rooms and what they wanted to do. We were told by care staff that they left people to make their own choices on this matter.

This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

All of the visitors told us that they could and did visit at any time of the day. However, they did try and avoid meal times, purely to allow the residents to enjoy their meals.

We found the care planning process centred on individuals and their views and preferences. Care plans contained information about people’s life histories. This information supported staff’s understanding of people’s histories and lifestyles and enabled them to better respond to their needs and enhance their enjoyment of life.

We saw evidence regarding person/family involvement in care planning as part of the ‘My Review Meeting’ which took place on a monthly basis with the care manager. Examples of entries in the ‘My Review Meetings’ documentation included, “[Name] has said that staff are all good and is happy here”, “All care plans reviewed and still meet customer needs” and “Several discussions with son, no concerns”. This meant that people and their family members were consulted about their care.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated.

We saw pre-admission assessments had been carried out before people started using the service. Following an initial assessment, care plans were developed detailing the care needs/support, actions and responsibilities, to ensure personalised care was provided to all people. The initial assessment was also signed by the person.

Each care record contained a client profile, which included a photograph of the person. We saw one person's photograph was dated, however other people's photographs we looked at were not dated.

We saw 'My Living Story' and 'About Me' records completed for people who used the service, which gave staff an insight into people's needs, preferences, likes, dislikes and interests. Staff told us, "For people who are not able to come to activities I spend time on a one to one time with them, where I do their hair, brush it, plait it, care for their nails" and we saw evidence of this in the person's care plan.

Care plans we looked at were found to be detailed and gave a good overview of people's needs and the support they required, which meant that people's needs were met and the care was person-centred. Care plans included, oral care, skin integrity/tissue viability, continence, communication, mobility, medication and personal care. The care plans guided the work of care team members and were used as a basis for quality, continuity of care and risk management. The care planning system was found to be a simple system and easy to navigate. The care plans were reviewed monthly and on a more regular basis, in line with any changing needs. We saw they were signed and dated by a senior member of care staff.

We saw daily accountability notes were concise and information was recorded regarding basic care, hygiene, continence, mobility and nutrition. The daily notes were signed and dated by care staff. We reviewed the 'daily handover sheet', which detailed the staff present at the handover, the person's room number, the date and the handover details regarding the person. This meant that staff were kept up-to-date with the changing needs of people who used the service.

We saw that risk assessments were in place, as identified through the assessment and care planning process, and they were regularly reviewed and evaluated. Risk assessments were in place for nutrition, choking, continence, use of wheelchairs and use of hoists/slings. We saw falls risk assessments had been undertaken and it had not been deemed necessary to refer any people to the falls team. Records we looked at confirmed that no bed rails were used.

We saw there was a full activities schedule and the activities co-ordinator spent time with people on a one-to-one basis. We also saw that the local town mission visited the home once per month and another local church held meetings in the home once per month. We saw people had taken part in bingo, pamper days and singalongs. Some of the people were taken out by relatives or staff on a one to one basis.

Entertainers came into the home at least once per month and chair exercises were carried out once per week. We also saw a hairdresser attended the home two days per week and a chiropodist attended on a regular basis.

We saw a copy of the provider's 'Customer feedback – Handling complaints, compliments and suggestions' policy dated June 2014. We saw a copy of the complaints procedure in the entrance foyer at the home. We saw copies of complaints forms, which included details of the name of the complainant, who the complaint was made to and recorded by, details of the complaint, the findings of the investigation, any corrective action taken, considerations for future action and when the complaint was confirmed as resolved.

We saw a copy of the complaints log, which included a summary of each complaint and what action had been taken. For example, we saw one person who used the service had complained the water was too cold in their room. We saw a contractor had been called out and the issue was resolved the following day. We saw six complaints had been received since July 2014 and from the records we saw all had been resolved satisfactorily. The records included copies of documents relating to the complaint, for example, minutes of staff meetings between the registered manager, staff and the complainants.

We spoke with people who used the service and visitors regarding any complaints. Everyone we spoke with told us there was no need to complain. A visitor told us, "The staff

Is the service responsive?

are always trying to please. There is no need to complain." People who used the service told us, "I have no complaints. I am looked after very well" and "This place is wonderful. I love it. I am very content".

We spoke with visiting healthcare professionals about whether they had any concerns or complaints they told us, "No not in here", "Don't think so, the only concern I had was about hydration, as when I was taking blood I had asked the person to drink more. When we discussed the aforementioned with the care manager they could not recall people not having sufficient fluids and told us they would explore this further" and "No concerns regarding care, nothing springs to mind".

This meant that comments and complaints were listened to and acted on effectively.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

There was a friendly atmosphere in the home. One visitor told us, “When we were looking for a home for my mum, we looked at a few. When we came in here, we knew this was the one.”

We spoke with visiting healthcare professionals about the atmosphere in the home. They told us, “It’s really nice, it’s one of the nicer ones. It’s very organised, the staff take you to each person and stay with you, I wouldn’t mind living here”, “The atmosphere is really nice, they’ve got some lovely residents here, it’s a calm atmosphere, very calm, very friendly, I don’t feel there’s any tension between staff and no clients have complained about staff” and “It’s certainly one of the better ones”.

We spoke with staff about how they enjoyed working at the home and they told us, “Love it, been here years, love caring for people, it’s a lovely home to work in”, “We now have new en-suites, everything is working fine, we’re getting new paths, everyone is happy, residents are happy” and “Everybody in the home works well, it’s a happy family, staff come and they stay”.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. We saw the ‘Audits’ file, which included a copy of the home service improvement plan, which was updated every month by the registered manager and monitored by the district manager. This included action plans for any issues identified during the audit, including actions needed, date of completion, who the lead person was and the red/amber/green status. For example, one action was for all staff to complete e-learning on medication. We saw this had been completed on 31 March 2015.

We also saw the district manager carried out monthly location visits and looked at different themes on each visit, for example, nutrition, cleanliness and infection control, and medication. We discussed quality assurance with the district manager, who told us they visited the home every four to six weeks and had started using a new ‘Excellence tool’ to see whether the home was complying with CQC and other requirements. The registered manager completed the tool on a quarterly basis and it was validated by the district manager. We saw an electronic version of the report for April 2015.

We saw records of staff meetings, which were held monthly and a timetable showed they had been planned for the remainder of the year. The agenda for a meeting on 13 April 2015 included staffing and rotas, appointments, sickness procedure, holiday requests, cleaning and e-learning. The record also included a signature sheet for staff to sign to say they had read the minutes. We also saw minutes for care managers meetings, heads of department meetings and health and safety meetings. When asked about how frequently they had staff meetings with the registered manager, together with what was discussed, staff told us, “We have team leader meetings four to six weekly, we discuss problems and pooling ideas, concerns we discussed the last time and things actioned, the rota, medicines, health and safety and leader roles.”

Staff we spoke with told us they enjoyed the work and the satisfaction they got from supporting the people who used the service. We asked staff what support they got and were told they were well supported by local and regional management. We asked staff about the approachability of the home’s management team. They told us, “They’re both supportive, I speak to them every day”, “Whatever you need you get all the support you need, they’ll do anything for you including personal support” and “They’re also always at the end of a phone if we need them”.

During our inspection we spoke with visiting healthcare professionals about their views of the care staff and the management. They told us, “They all seem really good and competent, they have a good knowledge of the clients and know their little ways. The rooms are personalised and I feel the staff have known the clients for a long time. I never hear people shouting/buzzing, there always seems to be plenty of staff” and “Seems well organised, well run, they have always answered my questions, they’re up to speed”.

We saw records of residents’ and family meetings, which had taken place approximately every two months. We looked at the minutes for a meeting on 24 March 2015, which had been attended by 20 people who used the service and the activities co-ordinator. The agenda included easter activities, the gardens, birthday

Good

Is the service well-led?

celebrations, the grand national event and refurbishment plans. People we spoke with, and their family members, told us they were regularly consulted about what was going on at the home.

This meant that the provider gathered information about the quality of their service from a variety of sources.