Care UK Community Partnerships Ltd

Grangewood Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Grangewood Care Centre is owned and run by Care UK Community Partnerships Ltd. It is a large two storey residential care home situated in Houghton-Le-Spring. The service provided accommodation, personal care and support to 50 older people. At the time of our inspection the home was full.

This inspection took place on 14 and 15 June 2016 and was unannounced. This means the provider or staff did not know we would be visiting. We last inspected this service in December 2013, at which time we found them to be compliant against all of the regulations that we inspected.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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 was a safeguarding policy in place and the staff we spoke with understood their responsibilities with regards to protecting people from harm or improper treatment. People told us they felt safe living at Grangewood Care Centre with support from the staff. Relatives confirmed this. We reviewed the staffing levels and found them to be appropriate. People, relatives and staff told us they felt there was enough staff to meet people's needs safely.

Corporate policies, procedures and systems were in place to assist the staff to deliver safe, good quality care. We found electronic care records and staff records were accurate, detailed and up to date. Some care monitoring charts completed by care workers were not as comprehensive as they should be and this was to be addressed by the manager.

Personal emergency evacuation plans were in place and checks on the safety of the premises were carried out by maintenance staff and by external professionals as necessary.

Medicines were managed in line with safe working practices. We saw medicines were administered safely and medicine administration records were accurate and well maintained.

The registered manager and staff had a thorough understanding of the Mental Capacity Act (MCA) and their own responsibilities. The majority of people living at Grangewood lacked the mental capacity to make important decisions and the registered manager had applied to the local authority for deprivation of liberty authorisations. Other decisions which were made in people's best interests were carried out in line with legislation and guidance.

People were supported by staff to maintain a healthy and well-balanced diet. The catering was managed well and the food looked nutritious and appetising.

Staff received an induction upon commencement of employment and were trained in key topics to ensure they had the skills and knowledge to support people. Staff were also supported through regular supervision and appraisal. Staff told us there was good morale and they worked well as a team.

Staff displayed caring attitudes and treated people as individuals. We observed people were respected and their privacy and dignity was maintained by the staff who supported them. We saw staff gave people choices and encouraged them to make decisions where possible.

The service had adopted a person-centred approach and the care and support provided by staff was tailored to suit the individual needs of each person. The service offered a wide range of activities and supported people to maintain family and community links by welcoming visitors into the home. People and their relatives told us they knew how to complain and said they wouldn't hesitate to do so if necessary.

'Resident and Relative' meetings and annual surveys were used to gather opinions and feedback from people and their relatives about the service they received. The registered manager and provider carried out audits which showed they were monitoring the safety and quality of the service and action plans were devised to improve the service further.

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.

Safeguarding procedures were followed and people told us they felt safe.

Staffing levels were appropriate and people told us staff were available when they needed them.

Medicines were well managed and administered in line with safe working practices.

The premises were safe and well maintained.

Is the service effective?

Good

The service was effective.

People were supported by staff who were knowledgeable and skilled.

Staff were supported in their role through formal supervision, appraisal and team meetings.

The registered manager and staff had a good understanding of the Mental Capacity Act (2008) and made best interest decisions in line with legislation.

People were encouraged to maintain a healthy diet and had access to external professionals to support their health and well-being.

Is the service caring?

Good

The service was caring.

Staff displayed kind, caring attitudes towards people and visitors.

People were respected and their privacy and dignity was maintained.

People were involved in planning their care and support and contributed to the running of the service.

Is the service responsive?

Good

The service was responsive.

Assessments of care needs were thorough and person-centred. Regular updates and reviews were carried out.

There was a variety of activities on offer which were meaningful and interesting to people.

There was a complaints procedure in place and people knew how to complain. The complaints were investigated and responded to appropriately.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post who was meeting the requirements of her registration.

People, relatives and staff described an open culture with strong leadership.

Surveys were carried out to gather the opinion of people who used the service, their relatives and staff.

The registered manager and provider conducted audits to monitor the safety and quality of the service.

Grangewood Care Centre

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 14 and 15 June 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

We reviewed all of the information we held about Grangewood Care Centre prior to the inspection including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made by providers in line with their registration obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We contacted the local authority safeguarding adult's team and contracts monitoring team, to obtain their feedback about the service. We also asked external health and social care professionals for their experiences of the service. We asked the provider to complete a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. All of this information informed our planning of the inspection.

During our inspection we spoke with seven people who lived at Grangewood Care Centre and carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 11 members of staff including the deputy manager, senior care workers, care workers and catering staff, who were all on duty during the inspection. The registered manager was on annual leave at the time of the inspection; however the regional manager attended to support the staff. We also spoke with seven relatives and friends of people who used the service, who were visiting at the time. We spoke with one local authority worker who was visiting people to carry out assessments.

We spent time observing care delivery at various times throughout the day, including the lunchtime and teatime experience in both dining rooms. We carried out an inspection of the treatment room where the medicines were kept and looked at the kitchen and food preparation areas. We also observed people engaging with activities.

We examined five people's electronic care records in depth and reviewed their paper files. We also looked at other elements of people's care, including food and fluid intake charts and medicine management.

We looked at five staff recruitment and training files, including a mix of staff who carried out care and non-care related roles. Additionally, we examined a range of other management records which related to the quality and safety of the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe living at Grangewood Care Centre and that their belongings were secure. One person said, "I'm very happy here, I'm safe and comfortable." Another person said, "I'm very safe here". Their relation confirmed this was also their feeling.

There were safeguarding policies and procedures in place at the service and the staff we spoke with understood their responsibilities with regards to protecting people from harm. Staff told us, "People are safe here" and "I have confidence in the manager that processes are followed". The manager also followed local authority guidance and used a threshold tool to measure the severity of incidents. We reviewed 12 low-level incidents which had taken place in the last six months and saw the manager had recorded the details, investigated the incidents and escalated the information to the local authority and CQC as necessary.

Accidents and other incidents were also recorded. Information was thorough and up to date. Falls in particular were monitored and analysed to enable the manager to manage these closely. We saw that investigations had provided the manager with reasons behind the falls for example, urinary tract infections (water infections) or chest infections, as these infections can make people generally unwell, confused and disorientated. We also saw referrals had been made to the local falls team and to a physiotherapist in order to get additional support for people from external services.

Risk assessments were in place to reduce the likelihood of people coming to harm, such as in relation to mobility and behaviour. People's needs contained some element of risk and the staff had assessed this. Care records contained detailed instructions for staff to support people safely and provided preventative measures to avoid repeat occurrences. This meant the service had managed risks to individuals so that people were protected and supported.

The manager used a dependency tool called CAPE (Clifton Assessment Procedures for the Elderly), to determine staffing levels. CAPE is a nationally recognised tool which measured the dependency levels of people who used the service. The results were based on people's needs and took physical and mental health into account. The manager and staff used their experience and knowledge to determine when people's needs changed and they reassessed staffing levels on a monthly basis. People, relatives and staff told us they felt there was enough staff employed at the service to care for people safely. People and relatives told us staff responded to them quickly and medicines were always on time.

Staff recruitment was robust. Staff files contained evidence of pre-employment vetting. Two written references were obtained, identity was verified and a check was carried out with the Disclosure and barring Service (DBS). DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role for which they are to be employed. A formal application process was in place and a thorough interview took place which was specific to the role being applied for.

The premises were well maintained. The service employed a maintenance worker to carry out repairs and

routine safety checks. We reviewed the maintenance records and saw daily, weekly and monthly safety checks took place. Where faults were identified, remedial action and further action to involve external services was documented. The provider was legally responsible to have checks on gas, electric and water carried out by approved contactors. We observed records and safety certificates which confirmed these had taken place as necessary.

The service had a business continuity plan in place in order to ensure people continued to be cared for in the event of major disruption such as fire, flood or loss of power. Staff were trained in health and safety and more specifically in fire safety. Fire safety checks took place and the maintenance worker had conducted practice evacuation drills with staff. The service had created personal emergency evacuation plans for each individual and they used a 'traffic light' system to identify people's level of needs. For example, red spots were placed on bedroom doors to enable staff and emergency services identify who needed assistance to evacuate the building.

Medicines were well managed and safely administered. We carried out an inspection of one treatment room and shadowed a senior care worker as they administered medicines to people. The senior care worker demonstrated knowledge and competency whilst completing the tasks. They displayed a thorough understanding of the company's medicines policy and procedures. We observed the senior care worker approaching people carefully and gently explaining what the medicines were for. They encouraged and supported people to take their medicines in a relaxed manner.

National best practice guidance was followed and we saw medicines were stored safely and securely. There was a procedure in place for the ordering and disposal of medicines, which we saw was followed correctly. We carried out a random check of the stored medicines and found it to be accurate. The senior care worker completed the medicine administration records with care and attention. We saw previous records were accurate and well maintained.

Good

Is the service effective?

Our findings

Staff were trained in key topics specific to their role. The service used a range of training providers to deliver staff training. External professionals such as the challenging behaviour team also provided training sessions based around the individuals needs of people. All the staff we spoke with told us they received regular training and they felt confident and competent to carry out their role. Senior care workers had achieved higher level qualifications in health and social care and completed advanced training in medicine management. Staff told us they were encouraged to learn and develop themselves. Staff told us they had attended training in topics which were of particular interest to them such Dementia, Parkinson's and other conditions which the people they cared for suffered from. This demonstrated that people received effective care from staff who have the knowledge and skills to carry out their role responsibly and the training records confirmed this.

There was evidence in staff files that an induction process had been completed by staff when they were first employed. More recently staff undertook the 'Care Certificate'. The care certificate is a benchmark for the induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. A senior care worker had been trained as an assessor of the care certificate and we saw evidence of new staff being supervised closely and their competency monitored. Probationary reviews were used by the manager to assess new starters for a period of time.

Supervision and appraisals were in place and staff told us they received regular one to one time with the manager or deputy manager which they found "valuable". One member of staff said, "It gives you a chance to voice anything in private and it gives you a chance to ask for further training." We reviewed four supervision records and saw discussions were recorded around strengths, improving performance, standards of care and training opportunities. Appraisals measured competence and produced a performance assessment score. Specific aspects of the role were discussed such as communication, team work and personal development. Staff had assessed themselves and the manager had added their comments and any actions which could be taken to enhance performance such as shadowing a colleague to learn a new task.

Communication between the staff and management was good. We attended one of the daily handover meetings and observed the senior care worker passed over information about the health and social needs of each individual in their care. Key aspects of daily life were discussed which included, well-being, routine, sleep patterns, mealtimes and visitors. Handover forms were completed as a written record of the meeting. We reviewed previous handover notes and saw that these discussions always took place however the notes were not always as comprehensive as they could be. We informed the regional manager of this and they assured us they would discuss this with the manager in order to improve these records. Daily notes were written by care workers and inputted in a timely manner onto the electronic records. We found these to be relevant, detailed and up to date.

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 it is in their best interests to do so and when it is legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA. Care records showed, and the deputy manager confirmed most people living at the home were subject to a DoLS. We reviewed the records regarding the application to the local authority and outcomes of these decisions. The manager had also notified the Care Quality Commission of these as they are legally required to do so. We saw evidence of 'best interest' decisions being made for people who lacked mental capacity around personal care, voting and hospital avoidance. People who lack mental capacity may still have the ability to consent to some aspects of their care and treatment. People should be included in the best interest decision making process along with their supporters. We spoke with a 'Best Interests' assessor from the local authority who was visiting the service. They give some very positive feedback and said, "All is as it should be here, the staff are very helpful and they are managing the best interests and DoLS well." This showed that the service sought consent in line with legislation and best practice guidance.

We observed staff ask for consent before assisting or attending to care and support needs, however the care records we reviewed lacked formal written consent to the plan of care. Only one of the five records we reviewed had the consent page completed and signed by the person or someone acting lawfully on their behalf.

Care records demonstrated that people had good access to external professionals such as GP's, district nurses and chiropodists to support their health and well-being. We asked people if they regularly saw these professionals and they told us they did. Relatives also confirmed the involvement of others in their relations care and support. We observed a GP, district nurse and diabetic screening nurse all visiting the service during our inspection.

The chef showed us around the kitchen facilities and we spoke to them in depth about managing the catering and providing an effective service to the people who lived there. Best practice guidelines were being followed as we saw separate storage and preparation areas for raw and cooked foods. The fridges and freezers were clean and well stocked. The kitchen staff monitored the temperatures of this equipment and also checked food temperatures before serving. The chef felt there were enough kitchen staff to provide a good service to people and they had time to carry out routine and deep cleaning as necessary. The chef showed us a board on display in the kitchen which detailed the special dietary needs of people such as allergies, soft diet and certain dislikes.

Staff supported people to maintain a balanced diet and get enough to eat and drink. There were four care workers and a member of the kitchen staff present at mealtimes to support people if necessary. We observed a positive dining experience in both dining rooms over the lunchtime and teatime period. The dining rooms were invitingly set out and most people chose to sit in the dining rooms for their meals. Some people had chosen to remain in their room and the staff served their meals to them on a tray. Meals looked appetising and were well balanced with a choice of meat or fish, potatoes, and vegetables. A lighter meal of quiche and salad was also on offer. Soup and sandwiches, jacket potatoes and other snacks were also provided. There was a choice of hot or cold dessert with ice-cream, yoghurts and fruit were also available.

In the downstairs dining room, people had chosen in advance what they would like from the menu but they told us and staff confirmed that alternatives were always available if they changed their mind or fancied

something different. One staff member said, (Person) always has something different – they get what they want really." The chef told us they were happy to prepare anything they could if people wanted something else. In the upstairs dining room, both choices of meals were served up on a plate and staff showed people the food in order for them to make a choice. This was because the people living upstairs had higher needs and more complex dementia related symptoms. Showing people the food gave them the opportunity to recognise the food and pick what they wanted at that moment in time and it was more likely that they would eat their meal. This was an example of best practice in dementia care.

The premises were decorated in a way which also supported best practice in dementia care. Upstairs the corridors were themed such as 'the beach', 'the garden', 'the café' and there were memorabilia items on the walls. Ornaments, artefacts and other items such as hats, bags and pictures provided an opportunity for stimulation and reminiscence. Doors were painted in contrasting colours and had written and pictorial signage. People had their name and photograph on their bedroom doors. A new balcony had been opened in order for people upstairs to have easier access to outdoor space. Downstairs, the décor was welcoming and homely. There was pleasant decoration, music playing and ample communal space for people to socialise. To the rear of the property, there was a garden area with a large patio and a separate smoking area.

Good

Is the service caring?

Our findings

Staff had developed positive, caring relationships with people and their relatives. We overheard one person tell a care worker, "You are a lovely young lady". We spoke with two people who told us they had "made friends" and were "treated very well". Another person told us, "The staff were lovely and friendly." Relatives told us, "This is one of the better homes", "The staff are lovely", "They (staff) are lovely with my Mam and they were there for me too, I'm really grateful. Without them we couldn't have lived our lives" and "The worst experience of my life was made better by these nice people." We also saw numerous 'thank you' cards on display. Some of the comments included, "Thank you from the bottom of our hearts", "You are true professionals with a friendly touch" and "The staff are a credit to you."

The staff we spoke with demonstrated a genuinely caring attitude. They spoke with affection about the people they supported and displayed a kind, gentle and friendly approach during all of the interactions we observed. Staff made comments such as, "It's a nice home with a family atmosphere", I like it here, everyone gets on very well" and "I'm happy at work."

Staff were trained in equality and diversity and had also undertaken courses in specific topics which gave them a better understanding of people's diverse needs such as dementia awareness and diabetes. For example, staff were knowledgeable about how health conditions can affect people differently and understood how people's needs may differ even though they have a similar diagnosis. Staff told us they "treated people equally" and as "individuals". One member of staff told us, "We promote independence, they (people) might be slow but they must try, then you intervene but don't take it away from them."

The staff we spoke with described to us how they upheld dignity and respected people and their privacy. During our observations we saw staff knock on people's bedrooms doors before entering and closing curtains before attending to personal care. We observed a very positive interaction which occurred when a care worker realised one person had turned their blouse backwards. The care worker quietly spoke with the person and encouraged them to come to the bedroom to get changed. The care worker protected the person's dignity by placing a cardigan around the person's shoulders and calmly escorted the person to their room. We heard the care worker explaining what they were going to assist the person to do. This was an excellent example of maintaining privacy and dignity. A senior care worker told us, "We have staff who want to be here for the right reasons…I have never had to speak with anyone about (dis)respect."

People were involved in their care and support and in other areas of the service. Care records showed wherever possible people had been involved in their care planning by providing information about themselves including their life history, routine and preferences. One person told us, "I'm often asked to speak to people who are looking around the home; I show them my room and tell them what it's like to live here." The provider had recently introduced a 'Life History' booklet which included a family tree, information on family members, memorable events and past employment. Staff told us they had been asked in the team meeting to encourage people and relatives to complete these booklets which will help the staff get to know people better. Some staff told us they had already started to help people complete the booklets.

Information, advice and guidance were on display around the home on themed noticeboards and in communal areas. For example, there was a relative's communications board with information about activities, leaflets, a meal planner and important company policies such as complaints and safeguarding. A resident's magazine called "Our Voices" was produced and we saw it on display. The service also produced a newsletter which contained features which people and their relatives had contributed towards and there was a 'Resident and Relatives' forum which met regularly to discuss the running of the service. Inside these publications we saw the service had asked people for feedback and encouraged people and relatives to take an active role in the forum. A local befriending service visited people to encourage socialisation and inclusion.

People and relatives told us there was no restriction on visitors. One relative told us, "Mam had been here 10 days and her friends have come to see her from her last home – she's over the moon to see them." The staff had organised refreshments and biscuits in the dining room for the person to welcome four friends and her daughter for the afternoon. The friends said, "We have been made to feel very welcome" and "Great first impressions." We spoke with the person later on in the afternoon and she told us she was "really happy after a great afternoon with friends." This demonstrated the service encouraged people to maintain links with their family, friends and local community.

Formal advocacy services were advertised around the home and staff told us they would speak up for people if necessary and refer to a formal service where appropriate. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld. Most people had relatives who acted on their behalf and we saw examples in care records of families who had legal arrangements in place with relatives acting as a lasting power of attorney for finances and health matters for people who lacked the capacity to manage these.

Staff were trained in end of life care and we saw the service actively supported people during this stage of their life. Emergency health care plans were in place and where possible people had made advanced decisions about the care and support they would prefer such as 'Do Not Resuscitate' instructions. We saw in one care record where a person who lacked the capacity to make such decisions, the service along with a GP, social worker and relatives had made a 'best interests decision' for the person being treated at the home rather than being admitted to a hospital.

Good

Is the service responsive?

Our findings

The service used an electronic care recording system and maintained a small paper file as a back-up. The paper files were also used when meetings were attended by care home staff and to provide relevant information to professionals who visited the service. Care records were person-centred. We saw entries which read, "Hobbies include darts, western films and dominoes" and (person) dislikes clutter." The records had been written with the individual at the centre and contained specific information which related to that persons' needs, wishes and choices.

A comprehensive pre-assessment was carried out prior to any person moving into Grangewood Care Centre which enabled the service to decide whether they were able to meet the person's needs. Following an agreed admission, a detailed care needs assessment was carried out which assessed needs such as capacity, health and well-being, nutrition, continence, mobility and social needs. The service operated a key worker system which meant a nominated member of staff had responsibility for updating and maintaining a person's records. The records detailed the current situation in relation to needs and support requirements, expected outcomes and actions for staff. For example one record stated a person needed medication at a specific time to control symptoms of an illness. Other instructions included plans for moving people and the equipment which should be used. Important information such as allergies, diabetes, DoLS and personal emergency evacuation statuses were flagged up with red, amber or green lights on the main page of each record. A traffic light system was also used to identify when reviews and reassessments were due. All of the records we examined had been recently reviewed or updated following a change of needs.

Other care monitoring tools such as daily notes, observational checks following incidents and food and fluid intake sheets were in use. We reviewed recent documentation and saw that although staff were completing these daily, the records were not as thorough as they should be. For example some handover entries for evening shifts simply read, "Slept well", there was no mention of personal care, supper or activities in the evening. Food and fluid charts were not always completed. Totals were missing at the end of the day and none of the records we looked at were signed off as completed. Some charts had entries without portion size or amount consumed and one record simply read, "roast dinner" with no explanation of what that consisted of or how much was eaten. Monitoring food and fluid intake requires precise recording of what foods and fluids the person is ingesting in order to improve or address risks associated with malnutrition and dehydration. There were no concerns about nutrition and hydration needs being met, but records needed improvement. We discussed this with the regional manager during the inspection and they told us they would discuss this with the manager with a view to immediately improving these records through staff training.

The service provided a range of activities which were meaningful and interesting to people who used the service such as reminiscence sessions, arts and crafts, exercises, pampering, spiritual time, music and entertainment. We reviewed the information kept by the activities coordinators and saw they had conducted research into the benefits of activities for older people and people with dementia. The service used external resources from the National Activity Providers Association (NAPA) and The Alzheimer's Society which assisted them to provide stimulating and effective activities. One activities coordinator had posted

questions on a discussion board on the NAPA website in order to gather feedback on certain activities and find ways to improve their provision. At the time of our inspection the activities coordinators were organising a raffle and entertainment for National Care Home Open Day. We saw and heard the activities coordinator getting people and relatives involved with the event. The activities coordinators maintained their own noticeboard and the weekly activities programme was on display. We saw photographs of people engaging in recent activities. As well as group activities people had one to one time with the activities coordinator tailored around their individual choices and day trips were arranged to local places of interest. A senior care worker told us, "I recently went on a trip to Lumley Castle with a group of people and some other staff – it was a good day out, everyone enjoyed it…and the cream tea!"

Nobody who used the service or their relatives raised any concerns during the inspection. The external professionals we contacted prior to the inspection also did not share any concerns. The people and relatives we spoke with told us they knew how to complain and wouldn't hesitate to if necessary. One relative said, "Everything is running fine as far as I'm concerned. I would go to a relatives meeting if something needed bringing up." Another relative said, "I've no concerns, it's very nice – it came highly recommended and I can't fault it." On admission, people were given copies of the complaints procedure and a copy was clearly on display for people to access. We examined information which the manager kept regarding complaints. We saw a 'Register of Complaints' in place which enabled the manager to track trends in issues. We reviewed five historical complaints which related to issues such as communication and standards of care. We saw copies of acknowledgement letters, investigation notes and statements from witnesses which demonstrated a thorough investigation had been completed. The manager had sent outcomes letters to complainants which included an explanation, a solution and an apology. On one occasion a manager from another of the provider's services had investigated a complaint in order to ensure the investigation was fair and transparent. We also saw that where issues had involved a member of staff, actions such as additional training or supervision had taken place and were recorded. We also saw learning opportunities shared in staff meetings. This showed that the service listened to concerns and ensured they learned from it.

Good

Is the service well-led?

Our findings

The registered manager of the service was on annual leave during our inspection. However, we were fully supported to carry out the inspection by the deputy manager and the regional operations manager. The registered manager had been in post for almost two years and was registered with the Care Quality Commission. This means she had accepted legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run. The deputy manager and many other staff were also long serving employees.

Prior to our inspection we checked our records to ensure statutory notifications were being submitted and we found that they were. The registered manager had sent regular notifications to us about applications for DoLS and notifications of deaths or other incidents which had occurred at the home as she is legally responsible to do.

There was good leadership and management of the service. One person told us, "(Manager) likes perfection." And a relative said, " (Manager) runs this place good, she's fair, she goes one step extra to do things like entertainment and get that access to the outdoors [referring to the new balcony]." Staff told us all of the management team were "approachable and supportive". We heard comments such as "(manager) is really nice, firm but fair. She gets stuck in if needs be and does daily walk-rounds to check on everything", "(Manager) is managing the team well, she has brought this home a long way in the last 12 months" and "I like it here, I enjoy my job. (Manager) is marvellous; (deputy manager) is great too. There's good team morale, everyone gets on very well."

Staff and relatives said there was a culture of openness. "Her (manager) door is always open" they told us. People, relatives and staff told us that the manager was accessible and they could speak to her whenever they wanted. Staff also told us representatives from the provider were regular visitors. Staff meetings and 'Resident and Relative' meetings took place and we saw from the minutes that the manager was always present. The minutes from the meetings showed that feedback was encouraged and the manager actively involved people, relatives and staff in the running of the service. This showed that the service promoted inclusivity and a positive, open culture which centred around people.

The manger carried out audits on all aspects of the service. An annual self-audit took place whereby the manager audited the service in relation to aspects such as health and safety, medicines, nutrition, quality assurance, infection control and activities. This was combined with six monthly quality assurance actions. Overall the audits had a positive outcome and the information was transferred onto the manager's monthly report for the provider to have an overview. Staff told us the provider has a visible presence within the service and often came to check the standard of care.

We reviewed the provider's 'Quality Outcome Review' and 'Service Improvement Plan'. These were very thorough and comprehensive documents. We saw there was a high level of compliance with the items audited however; there was a lack of recorded actions against the small number of issues. We discussed this with the deputy manager and regional operations manager during the inspection. We were satisfied these

issues had been addressed but they told us in future they would retain the information of actions they take or create an action plan each month to ensure updates are recorded.

The provider conducted an annual survey called 'Over to You' with staff who worked at the service. We saw in 2015 the service had achieved a 100% response rate. The results were on display and we reviewed the comprehensive analysis which the provider had collated. For example, the results showed 100% of staff thought health and safety was taken seriously at work and100% of staff said they were treated fairly. The provider had highlighted most improved areas such as "My manager gives clear feedback" and "My manager is open to ideas and suggestions."

Other positive feedback read, 100% of staff are proud to work here", 100% of staff believe we go the extra mile for quality care" and "100% of staff believe the care of our customers is top priority". This feedback reflected the provider's core values of 'putting customers at the heart of everything we do' and 'together we make things better'.

Also in 2015 a 'resident satisfaction' survey had taken place, called 'Your Care Rating'. The results were on display and showed that 97% of people were happy living at the home. 100% of people agreed that staff were usually available when they needed them. Over all the results were very positive in all areas such as kindness, dignity, respect, privacy and safety. A new survey for relatives had been introduced for 2016 and we saw 11 relatives had responded. The overall score was 84% with comments being made such as, "They always ring me if there's a problem", "They know her character and what she likes" and I'm happy with the care Mum gets. When I did have an issue in the past they got it sorted." The feedback from the surveys showed that the service delivered good quality care.

The provider had staff recognition schemes in place and rewarded staff for 'Going the Extra Mile'. People, relatives and staff could nominate a member of staff for a GEM award and the provider held an awards ceremony for staff nominated across all of their services. Staff told us they were awarded long service awards and had access to discounts with high street stores. One member of staff told us the manager had recognised the contribution of the team with a token gift at Christmas. This had made them feel appreciated and valued at work.