Rotherham Metropolitan Borough Council

Lord Hardy Court

Inspection report

Green Rise
Upper Haugh
Rawmash
Rotherham
S62 7DH
Tel: 01709 336188
Website: www.rotherham.gov.uk

Date of inspection visit: 15 August 2014
Date of publication: 17/12/2014

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

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 pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Lord Hardy Court is a 60 bedded residential care home for older people with care and support needs, including those living with dementia. Accommodation is divided into four separate units, with facilities including a hair salon, a cafeteria and a ballroom. It is located close to Rotherham town centre. When we inspected the service in August 2013 we found no concerns.

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 and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

This inspection was unannounced. During the visit we spoke with 17 people who used the service and 12 friends and family members, who were visiting at the time.

At this inspection we saw there were systems to make sure people were protected from the risk of harm. Staff knew about safeguarding and we saw concerns reported had been dealt with appropriately, which helped to keep people safe.

People we spoke with told us staff were very nice and easy to talk to. They and their relatives and friends also told us they felt involved in their care and support.

Staff were following the principles of the Mental Capacity Act 2005 for people who lacked capacity to make a decision and the registered manager had previously made applications under the Mental Capacity Act Deprivation of Liberty Safeguards for authorisation in the case of one person whose liberty had been restricted.

There were enough skilled and experienced staff and there was a programme of training, supervision and appraisal to support staff to meet people's needs.

Staff were aware of people's nutritional needs and made sure they supported people to have a healthy diet, with choices of a good variety of food and drink.

People had individual personal plans that were centred on their needs and preferences and had a good level of information, which explained how to meet each person's needs.

There were activities available and this was an area the team were working on improving. Additionally, a local business was funding work to the garden, which would make it safer, more accessible, and more 'dementia friendly'.

We saw that staff were respectful and made sure people's privacy and dignity was maintained.

People said they felt comfortable to raise any concerns with staff. The service learned from incidents and from people's feedback and used this as an opportunity for improvement.

Staff told us the management team were very supportive and approachable and the team had supported each other through staffing changes a recent restructure had brought.

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?

Good

The service was safe. All the people we spoke with who used the service told us they felt safe. Family members said their relatives were kept safe and, overall they were happy with the care provided. Staff were trained to recognise any abuse and knew how to report it.

The registered manager was aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). There were policies and procedures in place and key staff had been trained. This helped to make sure people were safeguarded from excessive or unnecessary restrictions being place on them.

People had care plans and risk assessments associated with their needs and lifestyles. Staff were recruited in a safe way as thorough pre-employment checks were done before they started work.

Is the service effective?

Good

The service was effective. People were cared for by staff who were well trained and supported to give care that was tailored to people's individual needs. Specialist dementia training had been provided for staff to give them a better understanding of people's needs.

People had access to health care services which meant their health care needs were met.

People enjoyed the food and drinks provided. Their plans were clear about what they liked and didn't like and included guidance about their special diets.

Is the service caring?

Good

The service was caring. People told us the staff were kind and caring. We saw that staff showed patience, gave encouragement and had respectful and positive attitudes.

The staff we spoke with had a good understanding of people's needs and preferences and we saw that they encouraged people to be independent.

People who used the service and family members told us they felt staff listened to them and valued what they said.

Is the service responsive?

Good

The service was responsive to people's individual needs. Staff asked people's views, encouraged them to make decisions and listened to and acted on them. This was done through daily interactions with staff, as well as more formally in meetings and surveys. People we spoke with felt comfortable to talk to staff if they had a concern and were confident any concerns would be dealt with.

People benefitted from the activities provided and the team and the 'Friends' group were working to improve what was on offer.

Summary of findings

Is the service well-led?

Good 

The service was well led. The home had a registered manager who provided effective leadership and was committed to the continuous improvement of the service.

There were systems to assess and monitor the quality of the service and to continually review safeguarding concerns, accidents and incidents and learn from them.

The management team asked people to give feedback about their care and support to see if there were any improvements they needed to make.

Lord Hardy Court

Detailed findings

Background to this inspection

The inspection team consisted of a lead inspector, a specialist professional advisor in dementia and mental health care and an expert by experience with expertise in care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection team consisted of a lead inspector, a specialist professional advisor in dementia and mental health care and an expert by experience with expertise in care of older people. 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 our inspection we reviewed all the information we held about the service including notifications received by the Care Quality Commission. The provider, Rotherham Metropolitan Borough Council, sent us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted Rotherham Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We spoke with a representative of the Rotherham council contracts team to get feedback about the service and they had no concerns to share with us.

We inspected the service on 15 August 2014. We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with 17 people who used the service and 12 friends and family members, who were visiting at the time. We spoke with the registered manager and seven members of the care team. We also met a quality assurance manager and the general manager. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at six people's written records, including the plans of their care.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Using SOFI we spent time observing three people. This showed us there was positive interaction between these people and the staff supporting them.

We last inspected in August 2013 and found the service was not in breach of any regulations at that time.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

We spoke with 17 people who used the service and 12 friends and family members. The consensus was that everyone felt safe in the home. A family member visiting a person in the late stages of dementia said, “He’s safe here and in fact everyone is.” They said they visited the home three times a week and had always felt comfortable when leaving. They said, “I can go home and not have to worry and know that he will be OK.”

Three people living in the residential unit also expressed their satisfaction with the care provided and said they felt safe. For example, one person said, “They would never do anything to hurt you here, not like some places, and I would call it a ‘home from home’.” Another person in the unit said, “There is complete safety here.”

The staff we spoke with showed they understood their role in safeguarding people from abuse. They described signs which might indicate possible abuse or neglect. They understood the procedure to follow to pass on concerns and felt these would be dealt with by senior staff. All the staff we spoke with said they would not hesitate to report any concerns. They said they had read the whistle blowing policy and would use it if they felt there was a need. The staff training records showed staff had received safeguarding training and updates and the staff we spoke with confirmed this.

The registered manager had referred safeguarding incidents to the local authority safeguarding team and to the Care Quality Commission appropriately.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. The staff we spoke with during our inspection understood the importance of the Mental Capacity Act in protecting people and the importance of involving people in making decisions. They told us they had training in the principles of the Act and the registered manager told us further training was planned. The training records we saw confirmed this.

In the pre-inspection information the provider told us that if people lacked the capacity to make decisions in their own best interest, capacity tests were undertaken. These were followed by a best interest meeting to establish what the person would want and access to an advocate could be arranged if there was no one acting independently on the person's behalf. The records we saw confirmed this. For instance, we saw records in two people’s files of ‘best interests’ meetings that had taken place and that decisions made on people's behalf were made in accordance with the principles of the Mental Capacity Act 2005. People who were important to the person and involved in their life were involved in the meetings, along with staff from the home and other professionals.

The Mental Capacity Act 2005 includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a ‘Supervisory Body’ for authority to do so. As Lord Hardy Court is registered as a care home, CQC is required by law to monitor the operation of the DoLS, and to report on what we find.

We asked whether anyone was subject to a DoLS authorisation and at the time, no one had a DoLS in place. Our discussion with the registered manager and the records we saw showed they were aware there had been recent guidance about the way the Deprivation of Liberty Safeguards were interpreted, widening their definition. The registered manager had been proactive and had discussed what action the service should take to make sure they met the key requirements of the Mental Capacity Act 2005 and were following a plan of action to put these into practice. The registered manager showed us the records of previous applications for DoLS and we saw that correct procedures had been followed to make sure people’s rights were protected.

Two people whose records we saw had ‘Do not attempt resuscitation’ (DNAR) forms at the front of their records to show that if they had a cardiorespiratory arrest, cardiopulmonary resuscitation (CPR) should not be attempted. The forms were fully completed and had been reviewed. In both instances close family members had been involved in the decisions. Both records showed that family members had been consulted.

Although the staff we spoke with were generally clear about their role in promoting people’s rights and choices, in the unit for people living with dementia we noticed that the

Good

Is the service safe?

patio doors leading out to the garden area were locked. The staff told us if someone wanted to go out into the garden they could ask for the door to be opened and go out into the garden, under supervision. This was because the ground was uneven, so people were at risk of falling. However, people told us they were happy and nobody asked to go out while we were there.

One staff member said that in the past, someone had a fall, which resulted in a serious injury. They said this made them nervous about people's safety in the garden, especially if they were to go out unattended. We also noted that the doors to people's balconies were locked. We discussed with the registered manager how people could be enabled to use the garden and their balconies and stay safe. She explained that a local business was funding work to the garden, which would make it safer, more accessible, and 'dementia friendly'. She showed us evidence of the improvements that were planned.

We looked at how the service managed risk. People's choices and decisions were recorded in their plans and reviews. People who used the service and the staff told us people were supported to take risks so they could be independent. The records we looked at had an assessment of each person's care and support needs and risk assessments specific to their needs, with care plans for each risk that had been identified. For instance, people had been assessed each month about risks with their nutrition. The service used a Malnutrition Universal Screening Tool (MUST). This is a screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. People had care plans about their nutritional needs.

We saw that where it had had been identified that someone may display behaviour which challenged the service there was guidance for staff in people's plans and risk assessments to help them to deal with any incidents effectively. These focussed on staff using the least restrictive approach, diverting people's attention and de-escalation and included respecting people's dignity and protecting their rights.

We looked at how the service managed staffing and recruitment. There were sufficient staff on duty to keep people safe during our inspection. The registered manager explained people's dependency was assessed and staffing levels reviewed based on people's assessed needs and risks. Staff said there were usually enough staff to meet people's needs and, although there were busy times, there were also quieter times, when they could spend time with people.

We saw staff had time to spend with people. We found call bells were answered promptly and we saw people's needs were being met. This was confirmed in discussions we had with people who lived at the home. One person told us they needed assistance at night and had not experienced any problems with staff responding to their call bell. Other people also told us there were enough staff. One person said, "If you sound your buzzer they are always there in two minutes." Another person said, "Even at night there are enough staff."

By contrast, two visitors to the rehabilitation unit said, "We don't see any staff when we come here." When asked if they had sought out staff they replied that they hadn't but expected staff to be around. During our visit we checked if there were staff available in the unit and found there were. Most were attending to people's needs, in their bedrooms.

People chose what input they required from the night staff. For instance, one person said, "You can choose whether or not you want them to come in to you during the night." Another person said, "I feel alright on my own, so I don't ask them to come in" while another person said, "They come in three times during the night to see that I am alright."

Most people had a personal buzzer, either round their neck or on their wrist, so they could use them to call for staff if they were not able to reach the buzzers that were in their rooms and the toilets.

We looked at recruitment records of five staff members and spoke with three staff about their recruitment experiences. Checks had been completed before staff worked unsupervised and these were clearly recorded. The checks included taking up written references, identification check, and a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

The recruitment system included applicants completing a written application form with a full employment history and a face to face interview to make sure people were suitable to work with vulnerable people. We saw that

Good

Is the service safe?

interview notes were kept on each staff member's records to show that the recruitment process tested candidate's suitability for the role they had applied for. Staff told us they went through an induction period and had induction training.

Is the service effective?

Our findings

We looked at how the service trained and supported their staff. We found that staff were trained to help them meet people's needs effectively. All staff had under gone an induction programme when they started work in the home and received regular mandatory training. All the staff we spoke with said their managers were good at making sure staff had the relevant training. They said the induction and on going training they had was useful and helped them feel confident to support the people who used the service. They all said they felt they worked in a supportive team and the registered manager was supportive, open and approachable.

We saw that staff received training in areas such as health and safety, moving and handling, emergency first aid, food hygiene, medication policy and infection control. Other training included speech and language therapy and communication disorders, preventing dehydration and urine infection, catheter maintenance and preventing hospital admissions. Staff also undertook bespoke training in the safe use of the equipment people needed to support their care, such as hoists.

One unit specialised in caring for people living with dementia. We spoke with people who used the service in the unit. One person said, "We've got lovely staff here I can tell you that."

We saw that staff had received training in dementia care mapping and dementia awareness and related well to people. Dementia care mapping is a set of observational tools designed to evaluate quality of care from the perspective of the person living with dementia.

We looked at how people were supported with their health. Staff told us people were registered with a GP who visited in response to people's health needs. The GP also carried out annual reviews of people's medicines. People had access to speech and language therapy (SALT), dietetics, physiotherapy and podiatry services via the GP. We were also told the service was supported by three advanced nurse practitioners, who carried out annual health checks and dementia screening and provided support and advice with all physical aspects of people's care. District nurses attended the home daily to administer insulin to some people and provide other health care treatments. Community psychiatric nurses (CPNs) also had input, as needed.

The records we saw showed people's health needs and preferences were known and kept under review. One person's plan had been reviewed twice since they moved to the home seven months ago. The first review took place three months after they moved to the home and the second review was three months after that. The first review was attended by the person's daughter. Their health care needs and preferences and their progress to independence were the main focus of their reviews.

We saw three people's health care plans. People had been involved in completing them. They showed that staff supported people to have access to health care services. For instance, the services involved in one person's care included the GP, an advanced nurse practitioner, a SALT, a CPN, a chiropodist and an optician. They had been referred for physiotherapy and commenced on an exercise programme. We saw evidence in their daily records that they were supported daily by the care staff with their exercises. They had also started a course of reflexology.

We looked at how people were supported with eating and drinking. We looked at the menu and, although it was varied, some teatime meals did not deliver much nutritional content. However, we checked four people's files and they included information about the areas they needed support with and any risks associated with their nutrition. For instance, people at risk had input from a dietician about special diets. People's weight was checked at regular intervals and this helped staff to make sure people maintained a healthy weight.

We saw the advice from a speech and language therapist about what foods were appropriate for people when they needed a soft diet. We also saw that people's religious and cultural needs and preferences were catered for. People's plans also included any special equipment they used. This included things like plate guards and adapted cups, which helped them to be as independent as they could be with eating and drinking.

There was universal praise for the meals at the home, from people who used the service and from the visitors we

Is the service effective?

spoke with. One person said, “You have a choice of what you want” and went on, “For breakfast, for example, you can have any kind of cereal or a bacon sandwich, or anything you want.”

People told us there was a flexible approach to the times for breakfast, and there were set times for the lunch and tea time meals. A cooked meal was offered in the middle of the day and a lighter meal, such as soup and sandwiches at teatime. Staff told us people were offered something to eat and drink for supper, although this was not shown on the menu. One person said, “If you ask them you can have a biscuit or even a sandwich with your drink.”

The tables in the dining area were nicely dressed, with serviettes displayed in tumblers and tablecloths on the tables. There were also condiments, such as salt and vinegar available on each table. The people who used the service had places in which they preferred to sit and, in the residential unit there was quite a ‘lunch club’ atmosphere, with people who used the service interacting spontaneously with each other and with the staff. We saw there was plenty to drink available throughout the day. At lunch time each person was supported to make choices and prompted appropriately. One member of staff was familiar with people’s preferences and was heard to say to one person, “Oh look, your favourite is on the menu for lunch.”

One person said, “Food is nice here and you get a choice.” One visitor said, “The food always looks and smells nice” and another visitor told us their relative had eaten very little before they came in to the home, and had visibly put on weight since moving there. There was a provision for families and visitors to have a meal at the home on Thursdays and this was appreciated by a number of those we spoke with. One visitor who had taken up the option to eat there said, “It is a really good meal, with a reasonable price tag, and I think it is the same as the residents get.” Another visitor said their relative was, “Provided with really nice food” and laughed as they confided, “I wouldn’t mind being here myself.”

Good

Is the service caring?

Our findings

Our observations of the staff showed us they were kind and compassionate towards the people who used the service. One person who was at the home for respite care told us, "The staff are ever so good, carers, domestic, everyone." They went on to say, "I tell everyone, my GP, my social worker, everyone that this place is absolutely wonderful and they ought to send people here." Someone else said the staff, "Allowed them to have their own opinion, and were very caring."

One visitor was happy with the care her relative was receiving. They said, "They really look after (the person) here." Another visitor said of their relative, "They could not carry on at home and after being in here on respite care we asked for them to come back. We were very relieved that they did. Everything is spot on here and I would say I find the staff efficient and obliging."

Staff told us that, in a lot of cases, people had stayed at the home as part of a respite care programme, prior to moving in on a permanent basis. This had helped with the transition for the person, as they were familiar with the home. It also gave the staff the opportunity to get to know the person. In other instances, where people were not familiar with the home, the assessment and admission processes was designed to minimise any dis-orientation and distress they may feel.

The staff completed a comprehensive assessment of needs and risks covering all aspects of mental health, physical health, psycho social support, capacity and consent. All aspects of the process included the preferences of the person. This then informed the care planning process.

People had chosen what they wanted to bring into the home to furnish their bedrooms. They had brought their ornaments and photographs of family and friends or other pictures for their walls. This personalised their space and supported people to orientate themselves.

The staff we spoke with were thoughtful about people's feelings and wellbeing and the staff we observed and spoke with knew people well, including their personal histories. They understood the way people communicated and this helped them to meet people's individual needs. For instance, we saw that all staff on duty communicated with the people who used the service effectively and used different ways of enhancing communication by touch, ensuring they were at eye level with people who were seated, and altering the tone of their voice appropriately for those who were hard of hearing.

The people's plans we saw included people's religious and spiritual beliefs. People told us they made decisions about their lives and made lots of choices every day. This included what they did with their time, what and where they wanted to eat and what clothes they wanted to wear.

The SOFI observation we carried out showed us there were positive interactions between the three people we observed and the staff supporting them. The staff showed patience, gave people lots of encouragement and had respectful and positive attitudes. We saw that the staff members engaged with people, talking about things people were interested in. They asked people how they were and if they wanted or needed anything and encouraged them to engage in activities.

People had their own, detailed personal plans. This helped to make sure care was individual and centred on each person. The plans included what was important to people and how staff should support them to maintain their privacy and dignity and people were involved in their planning.

Members of the team were dignity champions. The Dignity in Care campaign is hosted by the Social Care Institute for Excellence, and aims to put dignity and respect at the heart of care services. One person we spoke with told us that all staff always knocked on their door and waited before entering. During our visit we saw that staff attended to people's needs in a discreet way, which maintained their dignity. We saw people were well dressed in clean clothes and looked well cared for. One person said, "The hairdresser comes every Tuesday and Thursday. I've got a perm booked for next week." This facility was mentioned by a number of ladies in the home. One gentleman also said, "I get my hair cut here and they do a good job of it." One lady told us, 'The staff will always help you to put a few rollers in your hair, so that you look nice."

We looked at how people were supported to be involved and make decisions. The people we spoke with who used the service all confirmed they felt they were listened to. One family member visiting their loved one in the unit for people living with dementia felt that they were consulted about the person's care. They said, "There is a review every

Good

Is the service caring?

three months and I will be involved in that." They said their relative wasn't able to say what they thought, so they felt they were the person's 'voice'. They said they were, "not afraid to express concerns." They told us they had been unhappy about one aspect of the care and added, "When I took this up with the staff they listened to me and something was done."

Is the service responsive?

Our findings

People told us they were happy with the care and support they received from staff. One person said the home was, "Much better than living alone, there are people to talk to and staff to look after you. I like it." One person had two visitors. One said, "We are highly delighted with what happens here." They mentioned in particular the chiropodist and hairdresser who visited. They also thought independence was promoted in the home and that their relative was, "Treated like a human being." They told us their relative had not been able to walk prior to coming into the home and after staying in the home, could now do so, with a walking frame.

Another visiting relative said, "This place is impressive. I could not believe my eyes when we came in." He went on to say, "The place is clean and there is a good feeling here and I think they cater well for elderly people." On the other hand, another visitor said they thought that although the home looked nice, the atmosphere was "very flat" but they hastened to add, "I am still very satisfied with the care my relative receives."

The provider told us they promoted a culture of equality and diversity that challenged discrimination, and where people were made to feel welcome and accepted. This was embedded into recruitment, training and induction processes. During the inspection we saw that staff training included human rights, equality and diversity and person-centred care. Person-centred care is based on the goals of the individual being supported, as opposed to the goals of the system or as defined by professionals. The staff we spoke with said this training helped raise their awareness and make sure there was respect for people's diversity.

The provider also told us they were implementing an action plan for encouraging a more diverse staff team and they wanted to recruit more male staff to meet the needs of male service users better. The seven staff members we spoke with were knowledgeable about the needs of the people they supported. They were able to give us examples of choices they offered people and how they promoted people's independence. For instance, a staff member explained how one person was working on regaining their independence in walking and how the person liked staff to support them with this. We also saw people being accompanied to the dining room for their lunch and the staff facilitated them in a way that helped people to be as independent as they could.

We saw there was appropriate signage throughout the units, to help people with dementia to orientate. One lady was very proud of her room and asked us to go and look at it with her. She said, "Have you ever seen anything like it in your life? I've got a bathroom (toilet and shower) in my bedroom and a balcony."

We looked at six people's care records in detail and found they were clearly identifiable and accessible to the care staff. They were easy to navigate, properly completed and legible. People's plans were individualised and included their needs and their preferences. The records we saw consistently showed that staff were responsive to people's changing needs, showed that people were involved in their care and that their preferences and choices were respected. For instance, one person moved to the home around six months ago. Their person centred plan was reviewed in May and July and their relatives were at their three monthly review in May. Their plans had been updated regularly and changes were clearly highlighted. Staff had sought support from other appropriate services when needed.

Another person had lived in the home since 2009. There was evidence of regular, three monthly reviews taking place and their views and involvement was recorded. Their person centred plan was last updated in July and their preferences were recorded clearly, for example, "I would like to be checked three times during the night and offered a drink and something to eat." We saw evidence in the night records that this was done, as requested.

People were generally encouraged to make choices about their everyday activities such as what to wear, what to do and what to eat. When asked what would happen if they did not like the two choices of meal that were on offer we were told, "We would ask for something else and they would get it for us."

The activities were appropriate for people's ages and interests and people were asked if they wished to take part. We saw a member of staff respect one person's choice not to participate in the activity that took place on the morning of our visit. Throughout the day we saw staff engaged in

Is the service responsive?

conversation and activities with people in each of the units, including ladies having their nails varnished, and people playing dominoes during the late morning and early afternoon.

The service had undergone a review and restructure and the role of staff members who solely provided activities no longer existed. The provider had identified the activities available as an area for improvement. In the provider information return they sent us they told us that over the next six months, they planned to increase the range of activities available to people, develop a 'Friends' group and recruit community volunteers.

There were mixed opinions about the activities on offer. Four people we spoke with said they were happy with the activities and another two said there were activities on offer that looked fine, but they were not keen on joining in. One person said there were fewer activities compared with the previous year. They said, "Last year I made all my own Christmas cards and it was wonderful, but since the activities staff were finished the staff have to do what they can, around other pressing things to do." Another person we spoke with in the unit for people living with dementia said, "There aren't many trips out, we could do to go out a little bit more."

Two visitors also said the home were no longer providing the activities which had been available in the past and they said they "Thought this was a shame."

We spoke with a staff member who had volunteered to work with the Friends group and organise resources for activities. They said there had been a successful bid for Lottery funding and the group raised money through other fundraising activities. They told us about different activities people had tried and explained that activities and equipment the money had funded were focussed on what people said they liked. They also told us about recruiting volunteers to help provide activities on a weekly basis and said relatives were getting involved with the group. They were inspiring in their creativity and in their determination to use resources in the very best way they could, for the benefit of people who used the service.

We saw that progress was being made with the Friends group and recruiting volunteers. For instance, one visitor told us his wife came in once a week to work with the people who used the service, on a voluntary basis.

We looked at how the service sought people's views and managed complaints. In the provider information return the provider sent us they told us that people who used the service were encouraged to express their views and contribute in an active way in their own care plans and reviews. The provider told us people were encouraged to contribute to developments of the home through quality surveys and 'residents' meetings'. The records we saw confirmed that people had a chance to say what they thought at their meetings.

The provider told us they worked within the Rotherham Metropolitan Borough Council's comments and complaints procedure and a copy of the procedure was available for people in their bedrooms, as well as the communal areas. We confirmed this at our visit. For instance, there was a printed notice by the reception desk which gave details of what to do if you wished to make a complaint, although some people we spoke with had not noticed this.

When we asked people whether they knew who to complain to, most said they would complain to the staff and they were confident about making a complaint. One person said, "I would never make a complaint, but if I had to, then I would tell the staff and if nothing happened I would tell the manager." One person observed, "It could be difficult if you did not have any family visiting, because this would leave you vulnerable." Nevertheless, they felt that if they did have something to say they could, "Say it without fear or favour" and one family member we spoke with told us they had raised a concern. They said, "The matter was dealt with to my satisfaction."

There had been five complaints received in the last twelve months. We saw correspondence which showed these had been investigated and responded to in accordance with the complaints procedure.

Good

Is the service well-led?

Our findings

The service was led by a registered manager who had managed the home for several years. The registered manager told us she was committed to continuously improving the service. She told us she was supported in this by her line manager, who very often visited the home. The registered manager was also part of the wider management team within Rotherham Metropolitan Borough Council's Directorate. She met regularly with other managers to discuss and implement policy changes and share best practice in specific areas of work. They told us there were team meetings for the staff in the home, where staff contributed to service development and set goals and targets for improving practice. Staff had clear lines of accountability and defined roles, responsibilities and values. The staff we spoke with confirmed this.

In the provider information return the provider told us there had been a review and restructure of the service over the last 12 months. They told us the restructure had enabled changes and improvements within the senior management structure, in that senior staff (shift leaders) had adopted a more hands on approach in terms of care delivery. Shift leaders were based on the units, supporting staff in their role and giving clear direction around practice issues.

Rotherham Metropolitan Borough Council had a clear set of principles and ethics. These included choice, involvement, dignity, respect, equality and independence for people. We spoke with several staff during our visit and they answered our queries in an open and helpful manner. They said the values of the Council and of the home were clear and they demonstrated a good understanding of these values.

The staff members we spoke with said communication with the management team was good and they felt supported to carry out their roles in caring for people. They said they felt confident to raise any concerns or discuss people's care at any time. Two staff we spoke with told us they received supervision on a regular basis and supervision records were kept. A care assistant told us, "Management are very supportive and approachable, you don't have to wait for supervision if you need to discuss something." The accessibility of the management team was echoed by a shift leader. Two more staff told us staff meetings took place regularly and they felt confident to share their views. They were aware of the Council's policy about whistle blowing and told us they were supported to question practice.

They said they were part of a strong team, who supported each other. There had been some media interest about the home, following the death of a person who used the service and this, combined with the restructure, had affected staff morale in 2013 and early 2014. They felt staff morale had improved since then and things were settling after the changes the review and restructure had brought.

One person who used the service said the registered manager often came to see them to ask if they were, "Happy with things." Two visiting relatives told us they were satisfied with the manager's responsiveness. One said the registered manager was, "Good and listens." Although there were pictures of the registered manager in the reception areas, some people we spoke with had not noticed these and said they did not know who the manager was, as they usually spoke with the care staff and shift leaders. We spoke about this with the registered manager who was disappointed and said she had an 'open door policy', tried hard to be visible in the units and worked evenings and weekends to help with this. She said she would try to find other ways to make sure people knew who she was and of her availability.

The registered manager was aware of national dementia guidance and said she was always looking for ways to improve the service. In the pre-inspection information the provider told us that they intended to introduce a dementia services design audit tool, created by Stirling University. This tool was designed to help services promote improvement in people's health and wellbeing and prevent and reduce falls, other accidents and behaviour that could challenge the service.

Satisfaction surveys were sent out annually to people who lived in the home, relatives and staff. Responses were analysed and the results posted in the home so people were informed of the outcomes and any actions taken. Six people's relatives we spoke with said that they had completed a satisfaction survey, one saying they thought, "It was in the last 6 weeks or so."

We found there were effective systems which ensured the registered manager was aware of any concerns. Monthly

Good

Is the service well-led?

audits of systems and practices were carried out by the by the registered manager of the home. Visits by the service manager and quality officers from outside of the home contributed to quality audits. Part of this was to check with people who used the service and their families what they felt about the service. There were also "Eyes and Ears" documents for professionals visiting the home to submit if they had any concerns about the home during their visits. Accident and incidents, including safeguarding incidents, were audited and any trends were identified and addressed.