Lakeside View 18 LLP

Lakeside View Nursing Home

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

Overall summary

This unannounced inspection of Lakeside View took place on 23 & 24 June 2015.

Lakeside View is a care home located in a residential area of Southport, near to the town centre. The aim of the service is to provide nursing care for people who are living with dementia and enduring mental health needs. All floors are accessed by a passenger lift and on the mezzanine level there is a stair lift. There is car parking space to the front of the home and a terraced garden.

A registered manager was 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.'

Relatives told us they felt their family member was safe living at Lakeside View as they received a good standard of care and support.

The staff we spoke with were aware of what constituted abuse and how to report an alleged incident. Safeguarding training was on-going for all staff.

Summary of findings

Our observations showed people were supported by sufficient numbers of staff who completed regular checks to ensure people's safety, comfort and wellbeing.

We saw the necessary recruitment checks had been undertaken so that staff employed were suitable to work with vulnerable people.

Sufficient number of staff were employed to provide care and support to help keep people safe and to offer support in accordance with individual need.

We found medicines were administered safely to people. Medicines were subject to regular review by their GP as part of monitoring efficacy.

Care files seen showed staff had completed risk assessments to assess and monitor people's health. These recorded staff actions to help keep people safe.

Systems were in place to maintain the safety of the home. This included health and safety checks of the equipment and building.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing.

The manager provided us with a staff training plan and this showed staff received training to ensure they had the skills and knowledge to support people. Staff told us they were supported through induction, on-going training and appraisal.

The manager informed us people who lived at Lakeside View needed support to make decisions about their daily life and care needs. Staff support was available to assist people to make key decisions regarding their daily life and care. Staff followed the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions. This however was not always fully evidenced in people's care files to support the decisions made.

Staff supported people to live as independently as they could. We observed staff gaining people's consent before assisting them with personal care, daily tasks or meals, for example.

People's nutritional needs were monitored by the staff. Menus were available and people's dietary requirements and preferences were taken into account.

People at the home articulated their needs and wishes in different ways and our observations showed staff understood and responded accordingly. Interactions between staff and people who lived at the home was caring, warm, gentle and respectful. Staff demonstrated a good knowledge of people's individual care, their needs, choices and preferences. This helped to ensure people's comfort and wellbeing.

People's care needs were recorded in a plan of care and support was given in accordance with individual need.

There was a relaxed atmosphere with plenty of chat between the people who lived there and the staff. People were able to take part in social activities however the manager was looking to develop social arrangements to provide a more varied activities programme.

The provider had a complaints procedure and information about how to make a complaint was provided to people when they started using the service.

We received positive feedback about the manager from staff, people who lived at the home and relatives. Staff told us there was good staff team and everyone was focused on ensuring people got the best care possible.

Arrangements were in place to seek the opinions of people and their relatives, so they could provide feedback about the home. This included the provision of satisfaction surveys and meetings held at the home.

Systems were in place to monitor to assure the service and to improve practice. The manager provided us with good examples where changes had been made to better support people however these were not always recorded to evidence the actions taken.

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.

Relatives told us they felt their family member was safe living at Lakeside View as they received a good standard of care and support.

We found medicines were administered safely to people. Medicines were subject to regular review by their GP as part of monitoring efficacy.

Recruitment checks were undertaken to ensure staff were suitable to work with vulnerable people.

Sufficient number of staff were employed to provide care and support to help keep peoples safe and to offer support in accordance with individual need.

Staff had completed risk assessments to assess and monitor people's health. We saw this in areas such as, falls, nutrition, mobility and pressure relief. Actions were recorded to ensure people's safety and wellbeing.

Is the service effective?

Good

The service was effective.

People's care records showed they had been supported to attend routine appointments with a range of health care professionals to maintain their health and wellbeing.

Staff followed the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions. This was not always fully evidenced in people's care files to support the decisions made.

People's nutritional needs were monitored by the staff. Menus were available and people's dietary requirements and preferences were taken into account.

Staff told us they were supported through induction, on-going training and appraisal.

Is the service caring?

Good

The service was caring.

People at the home articulated their needs and wishes in different ways and our observations showed staff understood and responded accordingly.

Interactions between staff and people at the home was caring, warm, gentle and respectful. Staff were at all times polite and took time to listen and to respond in a way that the person they engaged with understood.

Staff demonstrated a good knowledge of people's individual care, their needs, choices and preferences. This helped to ensure people's comfort and wellbeing.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People's care needs were recorded in a plan of care and support was given in accordance with individual need. People who lived at the home and relatives were involved in the plan of care however this was not always recorded to evidence their involvement.

There was a relaxed atmosphere in the home with plenty of chat and laughter between the people who lived there and the staff. People could take part in various social activities at the home.

A process was in place for managing complaints and complaints received had been investigated in accordance with the home's policy.

Arrangements were in place to seek the opinions of people and their relatives, so they could provide feedback about the home. People who lived at the home attended residents' meetings.

Is the service well-led?

Good

The service was well led.

The home had a registered manager in post. We received positive feedback about the manager from staff, people who lived at the home and relatives.

The home had a number of systems in place to monitor the quality of the service provided and improve practice. The manager provided us with good examples where changes had been made to better support people however these were not always recorded to evidence the actions taken.

The provider had a complaints procedure and information about how to make a complaint was provided to people when they started using the service.

Staff were aware of the home's whistle blowing policy and said they would not hesitate to use it.

Lakeside View Nursing 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 unannounced inspection took place on 23 & 24 June 2015. The inspection team consisted of two adult social care inspectors and a specialist advisor. A specialist advisor is a person who has experience and expertise in health and social care. The specialist advisor and second inspector attended the home on the first day of the inspection.

Before our inspection we reviewed the information we held about the home. This usually includes a review of the Provider Information Return (PIR). However, we had not requested the provider submit a PIR prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the notifications the Care Quality Commission had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spent time with five people who lived at the home. We spoke with the registered manager, two care staff, the chef, a registered nurse and general manager. We also spoke with five relatives and a health care professional to gain their views of the home.

As part of our inspection we used we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who use the service who could not talk with us.

We looked at the care records for five people, four staff recruitment files, medicine charts and other records relevant to the quality monitoring of the service. We undertook general observations, looked round the home, including some people's bedrooms, bathrooms, the restaurant (dining room), lounges and external grounds.

Good

Is the service safe?

Our findings

During our inspection we used a number of different methods to help us understand the experiences of people who lived at Lakeside View. This was because the people who lived at the home were not always able to communicate their needs and we were not always able to directly ask them their views or experiences about the home. A person was able to tell us they felt safe, as the staff were always there if you need a bit of help.

Relatives told us their family member was cared for safely at the home as they received a good standard of care. A relative said, "The staff always make sure (family member) is safe in every way, it gives me piece of mind."

Throughout the inspection we observed the staff supporting people in a discreet way ensuring their safety at all times. For example, we observed staff supporting a person who likes to walk around the home and for people who required some support with transferring, by the use of a hoist.

People were able to move around the home freely with or without staff support. Corridors were kept clear from equipment and the floors had no raised edges to reduce the risk of trips and falls. Throughout the day staff checked up on people's safety ensuring their comfort and wellbeing.

The majority of staff had received safeguarding training and further training was planned. All staff we spoke with were aware of what constituted abuse and how to report an alleged incident. A staff member told us it was to, "Protect the wellbeing and safety of people."

Safeguarding policies and procedures were available including the local authority's procedure for reporting issues. Contact details for the local authority were available for staff to refer to. We saw the manager has worked in accordance with the local authority's guidelines when reporting alleged incidents. They had assisted the local authority safeguarding team and agreed protocols had been followed in terms of investigating to help ensure any lessons had been learnt and efffective action taken. This approach helped ensure people were kept safe and their rights upheld.

There had been a number of safeguarded incidents around poor wound care management and the manager was able to show us the changes they had made to improve the management of pressure ulcers/wounds in the home.

We looked at how the home was staffed. Staff told us that there were enough staff on duty to ensure people received the support they needed. Our observations showed people were supported safely by the staff. During our inspection the manager was on duty with, a trained nurse, a senior carer, three care staff, chef, kitchen assistant, two domestic staff and maintenance person. At night the home was staffed with a trained nurse and two care staff. Two staff members came in at 7am as this had been found to be a very busy part of the day so extra staff support was provided at this time.

We looked at the staffing rota and this showed the number of staff available. The staff ratio was consistently in place to provide necessary safe care. Throughout the day, there appeared to be adequate numbers of staff to meet people's needs. For instance, during lunch we saw a person attempted to take a drink from a person sitting next to them; staff noticed this straight away and intervened, ensuring no distress was caused to either person. Staff also assisted people promptly when they needed personal care.

Relatives told us there were sufficient numbers of staff to support the people who lived at the home. A relative told us that the home did not appear short staffed and staff were attentive to people's needs.

The care files we looked at showed how risks to people's safety were assessed and how this information was used to record a plan of care. Risks assessments identified possible risks and the level of support required to help protect people from unnecessary hazards, thus ensuring people's safety and promoting independence where possible. We saw this in areas such as, falls, nutrition, mobility and pressure relief. The use of equipment such as, alarm mats, pressure relieving mattresses and bedrails was recorded. As part of monitoring people's safety, bedrooms had sensors connected to the doors to enable staff to be aware when people entered or left their room. This helped the staff to provide support in a timely manner and reduce the risk of a person falling.

We looked at how staff were recruited. We saw four staff files and asked the manager for copies of applications forms, references and identification of prospective

Good

Is the service safe?

employees. Disclosure and Barring Service (DBS) checks had also been carried out prior to new members of staff working at the home. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. The appropriate checks were in place to ensure prospective staff were suitable to work with vulnerable people.

We looked at how medicines were managed in the home. Medicines were kept secure in locked medicine trolleys. The majority of medicines were administered from a bio dose system (medicines dispensed in a sealed pack). We checked a sample of medicines in stock against the medication administration records and found these to be correct. We saw a small number of handwritten entries for medicines recorded; these did not evidence two staff signatures to reduce the risk of an error occurring when transcribing the information.

Medicines were administered by the nursing staff. The MARs (medicine administration record) were signed by the trained nurse once the medicines had been taken. We observed this during the lunch time medicine round. This helped reduce the risk of errors and our findings indicated that people had been administered their medicines as prescribed. We saw people's medicines were subject to regular review by their GP to monitor efficacy.

People's medical conditions and medicines were recorded in their care file. People did not have a separate support plan for their medicines. We saw the support people needed with medicines was recorded under specific care plans. For example, supporting people with their dementia or pain. The manager agreed to look at the way medicine support was recorded to ensure staff had all the information they needed to support people safely with their medicines.

The use of PRN (as needed) medicines was recorded and nursing staff were clear on the home's protocol around their administration. A relative told us their family member's pain was treated promptly by the staff at all times and this helped to improve their health.

We looked at the arrangements in place for giving medication covertly (hidden in food or drink) without the person's knowledge or consent. Administering medicines covertly is generally only necessary and appropriate in the case of people who actively refuse their medicines but who are judged not to have the capacity to understand the consequences of their refusal. We saw an example where a person received their medicines covertly. We saw evidence of external health care professional input regarding this decision though it was unclear as to whether a mental capacity assessment had been carried out to determine whether the person had the capacity to understand the implications of refusing their medication. This should be carried out in accordance with best practice and current guidance around decisions made in people's best interests. The manager said they would review their procedures around this.

Incidents that affected people's safety were documented and audited (checked) to identify trends, patterns or themes. The manager advised us of the actions taken in respect of incidents that affected three people who lived at the home. The actions had been taken in a timely manner to reduce the risk of re-occurrence and help ensure the person's on-going safety and wellbeing. These were however not documented and we brought this to the manager's attention.

Systems were in place to maintain the safety of the home. This included health and safety checks and audits of the environment. A fire risk assessment had been completed and people who lived at the home had a PEEP (personal emergency evacuation plan). Safety checks of equipment and services such as, fire prevention, hot water, legionella, gas and electric were undertaken; maintenance work was completed in a timely way to ensure the home was kept in a good state of repair.

We found the home to be clean and this included the laundry room and kitchen. Staff advised us they had plenty of gloves, aprons and hand gel in accordance with good standards of infection control. We saw these in use during the inspection.

Good

Is the service effective?

Our findings

People at the home articulated their needs and wishes in different ways and our observations showed staff understood and responded accordingly. Staff had had a good awareness and knowledge of people's facial expressions and body movements which had the potential to indicate pain, hunger, and when assistance was needed. People appeared comfortable and relaxed with the staff. A person who lived at the home said, "I am very happy here, the staff are very caring. I have everything I need."

Relatives told us their family member had good access to external health and social care professionals. A relative told us, "The staff are very quick to respond if a GP is needed." A number of health care professionals were visiting during our inspection and a relative had been invited to attend a care review. They told us they attended these regularly.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The five care files we looked at showed people had appointments with health and social care professionals such as, GP, social worker, wound care specialist, dietician, swallowing and language therapy team, mental health team and appointments with local hospitals. These appointments were documented and change of treatment or medicines, for example, had been actioned by the staff. A health care professional said the staff were providing care in accordance with people's needs.

The manager had an electronic training plan and course certificates were seen in staff files. Staff had received training in a number of areas. For example, moving and handling, Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), safeguarding, infection control, health and safety, medicines, dignity and end of life care. A number of people had some short term memory loss and staff had attended dementia and mental health awareness training. Staff told us they received a good standard of induction and training and were able to tell us how they put their learning into practice.

The need for wound care training around grading of pressure ulcers, classification of wounds and care of the skin for the staff had been identified by the manager; we saw this was taking place for nursing staff and senior care staff following our inspection. A wound care lead had recently been appointed in the home to oversee the management of wounds.

We saw systems were in place to provide staff support. These included staff meetings and approximately two monthly supervisions. The home has been opened just over a year and annual staff appraisals were now taking place. Staff said they received good training and support. They told us the manager had an 'open' door' policy and they attended meetings which was a good way of sharing information. Agenda items were structured and covered issues such as, infection control, training and key worker role for staff

The manager informed us that approximately 60% staff were trained at NVQ (National Vocational Qualification)/Diploma level. This was confirmed when looking at records and staff told us about the NVQ courses they had completed or were undertaking.

Relatives told us they felt the staff had a good standard of training which provided them with the knowledge to care for their family member. They commented on the good communication which existed in the home. A relative said, "The staff tell me if there is ever an incident or a change in my (family member's) condition." A person told us staff looked after them very well.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) (MCA). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. The manager informed us that the majority of people needed support around making decisions about thier daily life. The manager said staff sought consent from people and their relatives and involved them in key decisions around daily life and support and held meetings for specific decisions around people's care and welfare. This follows good practice in line with the MCA Code of Practice. The manager discussed a number of examples of recent practice which showed they were clearly aware of their roles and responsibilities under the MCA. It was however difficult to track through how a number of decisions had been made as this was not always clearly recorded as a 'best interest' meeting. We did see however evidence of external health care professional and relative involvement around the decision making process.

Good

Is the service effective?

The manager agreed to look at ways of recording this to better evidence the decisions made. Relatives told us they had attended meetings and been inlcuded in decisions about their family member's care and support.

With regard to the use of bedrails to help keep people safe the use of this equipment can be considered a form or restraint or restriction under the MCA. We did not see a 'best interest meeting' or discussion recorded with relevant parties regarding their use. The manager told us their use had been discussed with relatives and we saw the reasons for their use were documented in a plan of care.

During discussions with staff they told us they always asked for people's consent and that the home worked on the basis that staff were there to 'support' people to help them live as independently as they could. We observed staff gaining people's consent before assisting them with personal care, daily tasks or meals, for example.

The manager had applied for authorisation of Deprivation of Liberty Safeguards (DoLS) for a number of people who lived at the home. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. Information around the proposed restriction was recorded in people's plan of care and staff were aware of the support people needed. We found the manager and senior staff knowledgeable regarding the process involved if a referral was required.

We observed the lunch time meal and this was seen as a sociable occasion. There was a relaxed atmosphere and people were able to move freely around the restaurant (dining room) and to sit where they felt most comfortable for meals. Staff were observed to encourage people to eat their meals, returning frequently if they required further prompting and even trying varying approaches to promote people's independence. For example, one person was having difficulty with picking up food with a fork; staff noticed this and provided a spoon which the person was able to use more effectively, whilst maintaining independence and ensuring adequate nutritional intake. Staff were aware of portion sizes and what people enjoyed eating. People were offered a choice and also offered a later meal if they did not wish to eat when lunch was served.

A menu board in written and pictorial format was displayed in the restaurant (dining room), maximising the potential for people to be involved in decision making regarding meals. We saw the four week rolling menu and this offered a choice of two hot meals at lunchtime, two lighter options at dinner time as well as desserts. People were offered plenty of hot and cold drinks through the day and snacks such as, biscuits and cake mid-morning and afternoon. A person who lived at the home said, "The food is very good, the staff help me."

People were asked each morning which meal choice they would prefer for lunch and tea and the chef advised us that they always prepared an extra of each meal to allow for people changing their minds. If people do not want either of the options on the menu, the chef prepared an alternative. The chef said, "It's never a problem, people can have just what they want."

We observed very good communication by the staff with people during the lunch time period. We did note that staff did not always advise people of their meal choice when serving lunch. This would be beneficial as a number of people had short term memory loss and may not have recalled what they had chosen. Coloured plates had been introduced in accordance with good dementia care practice. The dark consistent colour, facilitated people to identify different foods on their plate.

People's dietary requirements, preferences and choices were recorded and known by the staff. Fortified milkshake drinks were available to people who ate little of their meals or required extra calories in their diet. When we talked with people about the menu their comments included, "Lovely", "Very nice indeed" and "Alright."

During a tour of the home, it was observed that each floor had been decorated to reflect themes, such as transport, a garden, music and seaside. There were pictures, stencils and relevant items on the walls for people to look at or touch. Spaces were being made to look like a train station and garden seating area, creating stimulating points of interest for people. Bathrooms had both written and clear pictorial signs to assist people in recognising them. One communal room had been designed to look like a library. We saw people sitting in the different areas during our inspection.

Good

Is the service caring?

Our findings

Interactions between staff and people at the home was caring, warm, gentle and respectful. Staff were at all times polite and took time to listen and to respond in a way that the person they engaged with understood. A staff member told us they enjoyed working at the home as they were allowed time to just sit and hold someone's hand and listen to them talk if that is what they need at the time.

There were a number of friends and relatives visiting during the inspection and there were no restrictions on visiting times, encouraging relationships to be maintained. Relatives' comments about the staff included, "Absolutely brilliant", "Fabulous", "The staff are wonderful" and "Carers are lovely." One relative explained that staff had offered a lot of support to their family and that staff had arranged support from other professionals which was such a help. Likewise a relative also reported on the patient nature of the staff when supporting people.

People's dignity was observed to be promoted in a number of ways during the inspection, for instance the use of dignity aprons at lunch times. Staff were observed to knock on bedroom doors before entering and seeking permission before entering. A staff member gave clear examples of how a person's dignity was maintained during the provision of personal care. Relatives said privacy and dignity was always respected by the staff in their day-to-day working.

Whilst staff supported people they offered plenty of reassurance and ensured their comfort before attending to someone else. Staff explained to people what they were going to do and they did not rush them. Support was given when people needed it and in a way they liked. We saw many examples to demonstrate this. For example, supporting people with personal care and meals.

The staff we spoke with presented as having a genuine concern for the wellbeing of the people they supported. They told us they knew how to support people to relieve their distress. For example, one person became agitated and staff were observed to manage this effectively and safely whilst maintaining the person's dignity. Staff appeared to know what would help alleviate the agitation for that person. A number of people liked to sit quietly and staff supported them to do this.

Some people went out with their family during our inspection; we saw staff providing support and reassurance to ensure their comfort and wellbeing prior to leaving the home.

Care plans viewed included brief details of a person's life history and preferences, yet the plans of care were detailed and staff were observed to have a good understanding of people's preferences, specifically regarding food and drinks and where/how people like to eat. For instance, one person was refusing to eat at the dining table and a member of staff advised a colleague to support person to a different area as they sometimes liked to eat alone.

People received care, as much as possible, from a consistent staff team. This meant people had the opportunity to build relationships with staff and that staff had the opportunity to get to know the people they supported well. The manager told us they had a good staff team and the staff had a good level of knowledge and understanding of people's individual needs. We observed this during our inspection.

The manager told us no one living at the home required the services of an advocate at this time. Contact details for a local advocacy service were available and the manager told us they would ensure these were displayed.

Good

Is the service responsive?

Our findings

We looked at how people were involved with their care planning. Due to needs associated with memory loss, the people we spoke with could not always recall whether they had been involved in developing their plan of care. One person we spoke said the staff chatted to them about their care and they 'knew what was going on'.

Relatives told us they were involved with their family member's care, this included the care plans, attending care reviews and informal meetings. A relative told us how helpful the care reviews were and how responsive the staff were if their family member's needs changed. When a medical issue had occurred a relative told us the staff had, "Dealt with it superbly." Care documents however showed however little evidence of people's involvement and/or relative involvement in the plan of care. We discussed with the manager ways of evidencing this, for example, by documenting this.

We looked at five people's care files and we saw people had a plan of care. The plans were individualised and very extensive; they also recorded individual needs and choices and reflected changes in people's care provision. The manager advised us these were very detailed to help staff who had not worked previously in care and to build up a picture of people's care needs. The manager appreciated that it may be beneficial to reduce the amount of information recorded, as vital information may not be picked up by the staff or be easily found. A summary care record was available in some care files we looked at. This provided an over view of people's care needs, their support and included information from the plan of care. The manager said work was on-going around the provision of a care summary record in all care files. Staff completed daily records about people's care and support in accordance with their plan of care.

We looked in particular at supporting people who needed support with their nutrition. People had a risk assessment and plan of care which was reviewed on a monthly basis or more frequently if required. People who were at risk due to a poor intake were provided with meal supplements and their fluids and diet were recorded. Nutritional records seen were up to date. People were also weighed to monitor weight gain or loss. For people who required specialist feeding via a percutaneous endoscopic gastrostomy (PEG) tube again this was well documented and in accordance with the plan of care.

Previous safeguarding referrals had identified the need to improve the management of pressure ulcers in the home as people were not receiving the support they needed. At this inspection we were able to see the improvements the manager had made regarding how pressure ulcers were assessed, treated and managed. People had a pressure sore assessment and for those who required care and treatment for pressure ulcers, wound care records were in place. These were updated once pressure ulcers had been dressed and were reviewed to monitor efficacy of the treatment plan. Body maps were in place to identify the position of the ulcers and care plans recorded the grade of the ulcer. The higher the grading of a pressure ulcer the more injury to the skin and tissue there is. Advice had been sought from an external wound care specialist at the appropriate time and staff were following their advice and treatment plans. We saw people had access to pressure relieving equipment to assure their comfort and promote healing.

We talked with the manager about updating the home's policy on wound care to include seeking advice from a wound care specialist for pressure ulcers above Grade 2 and also to take photographs of pressure ulcer damage, with people's consent. This is in accordance with national guidelines for wound care and helps provide an accurate visible tool for evaluation purposes and protect the care home when transferring a person to another care establishment.

Following an assessment of a person's needs the provision of 'one to one' support had been identified for them. During our inspection this support was provided in accordance with the person's care plan. A relative told us this level of support was consistently provided by the staff.

There was plenty of chat and laughter between the people who lived there and the staff. With regards to social support, details of of people's social background and interests were recorded in a social profile (life passport) to help staff get to know the people they supported. Talking with staff confirmed their knowledge about people's family

Good

Is the service responsive?

and social background. An activities plan was advertised in the home however the manager told us that this was not always followed. Activities tended to be staff led and on an informal basis.

We saw that a number of people who lived at the home went out with staff or their families and at the home people had a cinema room and hairdressing salon. Staff told us that with the warmer weather approaching trips out along the sea front and to the marine lake were planned. The manager told us they were recruiting an activities organiser for the home as they appreciated social activities was an area that needed development. Following the inspection the manager informed us a part time activities organiser had been recruited to help develop social aspects of the home.

The provider had a complaints procedure and information about how to make a complaint was provided to people when they started using the service. Relatives told us they would not hesitate to speak with the manager if they had a concern. We saw a complaints file and this recorded complaints received, actions taken and response to complainants.

Arrangements for feedback about the service included satisfaction surveys for people who lived at the home and for relatives. We were shown two examples of completed electronic surveys by relatives and these recorded satisfaction for the service in areas such as, cleanliness, staff, dignity, care and management. There was no overall analysis of the findings to help assure the service provision.

Residents' meetings were held to enable people to share their views about the home. The last meeting was held in June 2015 and points raised by people who lived at the home had been actioned.

Good

Is the service well-led?

Our findings

The home had a registered manager in post. The registered manager advised us they were stepping down from this position and a new manger had been appointed. The new manager is due to start in July 2015. The new manager will be required to apply to the Commission for Social Care Inspection for the position of Registered Manager.

We received positive feedback about the manager from staff, people who lived at the home and relatives. We were told the manager was approachable, always available and willing to listen. A member of staff told us they were able to raise ideas and make suggestions to improve the service. Relatives' comments included, "The manager is straight and honest" and "The home is really organised and (manager) leads it well." Staff were aware of the home's whistleblowing policy and said they would use it if needed. They said the management team listened and would make changes if appropriate.

Relatives made the following comments about the management of the home, "I am very happy with the standard of care here", "I am very happy with the choice of care home", "I am so glad we found this place" and "I hope we get a lot more quality homes like this." A person who lived at the home told us "I have everything I need here."

Staff told us there was good staff team and everyone was focused on ensuring people got the best care possible. We saw the manager working with the staff during the inspection. When one staff member was asked what they felt the service did well, they stated that the provider "Goes to great lengths to keep a person's individuality, the opposite of an institution and the home has an ethos that is family friendly, open and transparent."

A system of quality assurance had been implemented. This involved the management team checking on/auditing aspects of the home to monitor the quality of the care and standards to help improve practice. Separate audits were completed for areas such as, health and safety checks of the environment, bed rails, cleanliness, incident reporting, equipment and services to the home, fire prevention and medicines. Where actions had been identified these had been undertaken and lessons learnt shared with the staff to drive forward improvements. The manager provided us with good examples where changes had been made to better support people however these were not always recorded in the audits. We discussed ways or recording this with the manager and/or the completion of an overarching audit programme to ensure the manager is fully aware of performance in all areas of the home.

The home's six monthly health and safety / maintenance audit was completed on 24 June 2015 by the general manager; the home achieved a score of 96.5% (90-100% = Exceptional Standard on the rating scale). As part of monitoring infection control, an external infection audit by a local community health team was completed in February 2015 and the home achieved 91.26% for infection control standards. An Environmental Health Officer visited the home in April 2015 and awarded the home five stars for food, (five stars being the best score) based on how hygienic and well-managed food preparation areas were on the premises.

Medicine audits included a review of MARs to ensure medicines were administered to people in accordance with their prescription. We saw evidence of the home working in partnership with the pharmacist regarding current medicine supplies to help assure safe medicine practices.

The manager had signed up to undertaking an annual external quality assurance award. This looked at how the service was operating and included feedback from people involved with the service provision.

The home's policies and procedures were reviewed regularly to ensure the information was current and in accordance with 'best practice' and current legislation. The manager had notified CQC (Care Quality Commission) of events and incidents that occurred in the home in accordance with our statutory notifications