SHC Clemsfold Group Limited

Upper Mead

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

This was an unannounced inspection which took place on 22 May 2017.

Upper Mead provides nursing care and accommodation for a maximum of 48 older people. The home has a dedicated unit called Chestnut for people living with dementia. Accommodation is provided over two floors. Most rooms have ensuite facilities. There is a lounge on both floors of the home along with a quiet room that can be used by visitors and a large communal dining room. There is an enclosed courtyard garden area. At the time of this inspection there were 39 people living at the home (one of whom was in hospital when we visited).

During our inspection the registered manager was present. 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.

Upper Mead was last inspected on 8 March 2016 when it was given an overall rating of 'Requires Improvement'. Breaches of regulations were identified and requirement actions made. In response to these, the registered manager submitted an action plan that detailed the steps that would be taken to address the requirement actions. At this inspection we found that the requirement actions had been met and that the contents of the registered manager's action plan complied with.

People said that they were treated with kindness and respect. The atmosphere in the home was calm, relaxed and friendly. People's privacy was respected. Information was displayed in the home to help people understand choices about their care. Relatives were welcomed at the home.

Staff were skilled and experienced to care and support people to have a good quality of life. A training programme was in place that helped to ensure staff knowledge was current. Staff were confident about their role in keeping people safe from avoidable harm and abuse. They demonstrated that they knew what to do if they thought someone was at risk of abuse.

Risks to people's safety were managed. Some people had been assessed as being at risk of developing pressure wounds and they had skin integrity assessments in place. We saw these people had the correct profile bed in place and pressure relieving equipment to prevent their skin becoming sore. Regular checks on equipment took place to ensure it was safe to use and there was a system to report if equipment was faulty. The registered manager had a good oversight over accidents and incidents within the home and reported events appropriately to the relevant agencies including CQC.

People said that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively. The medicine management in the home was safe. People said that they were happy with the choice of activities on offer. Trips out into the wider community

took place and enhanced people's wellbeing.

The registered manager had taken appropriate steps to manage restrictions on people's freedom. DoLS applications had been submitted to the authorising authority for people who lacked capacity and were unable to leave the home freely. Mental capacity assessments were completed for people and their capacity to make decisions had been assumed by staff unless there was a professional assessment to show otherwise.

People said that the food at the home was good. People had choice over their meals and were effectively supported to maintain a healthy and balanced diet.

Everyone spoke highly of the registered manager. People said she was approachable and staff said they felt fully supported. There was a positive culture at the home that was supported by a registered manager who took steps to ensure this was inclusive and empowering. She was passionate about providing a quality service to people. People said they felt confident that issues and concerns would be acted upon when raised. Quality assurance systems were in place that helped ensure quality standards were maintained and legislation complied with.

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.

Risks were assessed and managed, with care plans and risk assessments providing information and guidance to staff.

There were enough staff on duty to support people and to meet their needs. Robust recruitment procedures were followed to make sure staff were safe to care for people.

People told us they felt safe. Staff understood the importance of protecting people from harm and abuse.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff were skilled and experienced to care and support people to have a good quality of life.

People consented to the care they received. Upper Mead was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The home followed the requirements of the Mental Capacity Act 2005.

People were supported to eat balanced diets that promoted good health.

People told us that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by dedicated and committed staff.

People were supported to express their views and to be involved

in making decisions about their care and support.

People were treated with dignity and respect. Staff were able to explain how they promoted people's dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care and treatment was provided in response to their individual needs and preferences.

An activity programme was in place and people expressed satisfaction with the range of activities available. Opportunities to access the wider community were available to people.

People felt able to raise concerns and were aware of the complaints procedure. Systems were in place that supported people to raise concerns.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted a positive culture that was open and inclusive.

Quality monitoring systems were being used to identify and take action to reduce risks to people and drive improvements at the home.

People spoke highly of the registered manager and said that the home was well-led. Staff felt well supported and were clear about their roles and responsibilities.

Upper Mead

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 22 May 2017 and was unannounced. The inspection team consisted of one inspector, a specialist dementia nurse advisor and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we asked the provider to complete 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 reviewed the completed PIR and we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the home. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spoke with 13 people who lived at the home and four relatives. We also spoke with two nurses, four care staff, the activity coordinator, the registered manager, an area manager and the head of quality and therapies. We also spoke with a GP who was at the home during our inspection. Prior to the inspection we made contact with four external health and social care professionals to obtain their views of the service provided to people.

Some people at the home were living with dementia and we were unable to hold detailed conversations with them. Therefore, we spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included six people's care and medicine records, staff training, support and employment records, quality assurance

audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports.

Good

Is the service safe?

Our findings

At our last inspection on 8 March 2016 we found that people did not always receive safe care and treatment and that robust safeguarding procedures were not always followed. As a result two requirement actions were made. In response to these, the registered manager submitted an action plan that detailed the steps that would be taken to address the requirement actions. At this inspection we found that the requirement actions had been met and that the contents of the registered manager's action plan complied with.

People said that they felt safe and we observed that they appeared happy and at ease in the presence of staff. One person said, Everyone is so kind and caring, their priority is to keep us safe." A second person said, "I am treated very well here." A third person said, "They look after me well, I have no problems."

Staff were confident about their role in keeping people safe from avoidable harm and abuse. They demonstrated that they knew what to do if they thought someone was at risk of abuse. Staff told us that the registered manager operated an 'open door' policy and that they felt confident she would act immediately if they raised any concerns about people's safety. They also said that they would report abuse to outside agencies such the local authority safeguarding team, the police or CQC if necessary

The registered manager demonstrated knowledge and understanding of safeguarding people and her responsibilities to report concerns to the relevant agencies. Since our previous inspection she had reported concerns when necessary to the local authority and to CQC. The registered manager had also ensured daily meetings took place with staff and nurses at the home. Records confirmed during these potential safeguarding matters and risks to peoples safety were discussed and action taken as necessary to protect people. For example, wound care management and care planning in response to wounds. Also, in response to concerns further training had been arranged for staff in relation to end of life care and dementia care.

Risks to people's safety were managed appropriately. Since our last inspection the registered manager had ensured the risk assessment processes in the home were reviewed and greater detail included. As a result, staff had all the necessary information to provide safe care and treatment to people. People had risk assessments in their care plans for identified areas such as catheter care, pressure area care and moving and handling. People who had been identified as at risk of skin breakdown had equipment such as pressure relieving mattresses and cushions. Pressure relieving mattresses were set correctly, according to the person's weight. We noted that as a result of the care being delivered to one person their pressure sore was improving.

Staff demonstrated appropriate moving and handling techniques when transferring people. Hoists were used and staff communicated with people clearly. Staff confirmed they were trained and updated yearly. One member of staff said, "I did my moving and handling training. I always do it safely and with two people."

The registered manager had oversight over accidents and incidents within the home. She completed monthly accident and incident audits that monitored that appropriate action had been taken when events occurred. These were also reviewed by an area manager and analysed to identify trends. For example,

records confirmed that action was taken including first aid when one person fell and sustained a graze to their back. When they fell again, arrangements were made for them to see a GP and a referral was made to the falls prevention team. When another person appeared to choke when eating, nurses provided first aid and the person recovered. As a result of this a referral was made to the Speech and Language Team (SALT) who assessed the person and their food consistency was changed from normal to fork mashable. There had been no further incidents as a result.

Environmental risks had been considered and mitigated. Each person had a Personal Emergency Evacuation Plan (PEEP) that provided guidance to staff in the event of an emergency situation. These were accessible to staff and the necessary equipment to aid evacuation was readily available throughout the home. Equipment and services in the home were checked and maintained to a safe standard. This included fire safety equipment, gas supplies and moving and handling equipment. A full time maintenance person was employed which helped to ensure prompt action was taken to maintain a safe and pleasant environment. On the morning of our inspection we commented to the registered manager that the first floor dining room was not decorated to the same standard as the ground floor facility. This was acted upon immediately and the dining room was repainted before we had left the home.

People told us that there were enough staff on duty to support them at the times they wanted or needed. People said that in the main, staff responded promptly to their requests for assistance. One person said, "Staff do respond to my needs but sometimes they are late because they are busy." We observed that there were sufficient staff on duty and that people received assistance and support when they needed it. Staff also said that staffing levels were sufficient to provide safe care. One member of staff said when asked, "Definitely. We are a good team and help each other out." A second member of staff said, "Staffing is okay. The manager covers the floor if needed for example if someone is very poorly and needs more attention. The agency staff they use are good too which really helps. They try and use the same people."

Staffing levels consisted of two nurses during the day, eight care staff during the morning and seven care staff during the afternoon. Of a night there were one nurse and four care staff. In addition to this, separate cleaning, kitchen and activity staff were allocated to undertake specific duties.

Appropriate recruitment checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This check helps to ensure staff are safe to work with people who use care and support services. There were also copies of other relevant documentation, including employment history and references, job descriptions and identification evidence to show that staff were suitable to work in the home. Confirmation was also in place that nurses were registered to practice with the National Midwifery Council.

The medicine management in the home was safe. Medicines were stored in a designated medicine room and in trollies which were allocated to areas of the home. These were locked and secured when not in use. Medicine Administration Record (MAR) charts were well maintained. Each chart included photographic identification, and any known allergies were noted and there were no gaps of signatures seen. Codes were used to explain why a medicine was not given for example if someone was in hospital or on leave.

Since our last inspection systems for the safe management of PRN (as required) medicines had been reviewed and improved. People who were prescribed PRN medicine were given these according to the MAR charts. PRN protocols were in place and we saw the nurse who gave people their medicines ask if they required this medicine. There were clear instructions for staff to follow regarding PRN medicine. These included what triggers may prompt staff to give this, when to give this, the maximum dose and safe time frames between doses. Medicine audits had also been reviewed and increased. As a result, prompt action

was taken when shortfalls were identified. The guidance for application of topical creams had also been reviewed and expanded. These included body maps that identified where the topical creams were to be applied, why they were needed and risks if they were not.

Staff followed safe medicine administration procedures. They locked the medicine trolley while it was unattended, washed their hands before giving people their medicine and only signed MAR charts when medicine had been administered. Nurses were knowledgeable about safe medicine procedures. They were able to explain ordering, storage, administering, disposal and auditing systems without referring to records.

People have the same rights to choose to manage their own medicines, including the right to refuse medicine, as people living in their own home. Staff was able to verbalise this, but there was limited documentation to support this work. This is an area for development.

Good

Is the service effective?

Our findings

People expressed satisfaction with the care that was provided. One relative said, "X (family member) has steadily declined due to their dementia but staff manage this fantastically. Staff are very accommodating to X and our needs. X doesn't like to leave her room but they do encourage her."

At our last inspection on 8 March 2016 we found that people's rights to consent and the Mental Capacity Act 2005 was not always followed. As a result a requirement action was made. In response, the registered manager submitted an action plan that detailed the steps that would be taken to address the requirement action. At this inspection we found that the requirement action had been met and that the contents of the registered manager's action plan complied with.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People said that they consented to the care they received and we observed staff confirming that people agreed to support before this was provided. One person said, "Staff consults me on what I wish to do and does what I have chosen."

Staff had received MCA training and understood the importance of gaining consent from people and were aware of the principles of the MCA. One member of staff said, "We have to ask permission and if they say no you can't force if they have capacity. If they don't have capacity you still can't force. You have to try and explain in best interests. For example if they are dirty you can't just leave them. Get another member of staff to see if they will agree to them helping. Record in care notes and tell the nurse." A second member of staff said, "We have to try and explain to the person and get their consent. Give choices and if they refuse explain the risks. Leave for a little while but go back or get someone else to see if the person will consent to our help."

Mental capacity assessments were completed for people and their capacity to make decisions had been assumed by staff unless there was a professional assessment to show otherwise. This was in line with the MCA Code of Practice which guides staff to ensure practice and decisions are made in people's best interests.

The registered manager had taken appropriate steps to manage restrictions on people's freedom. DoLS applications had been submitted to the authorising authority for people who lived in Chestnut unit who lacked capacity and were unable to leave the unit due to a coded key lock being in place. As part of this process mental capacity assessments had been completed which considered what decisions people had

the capacity to make.

During the morning of our inspection we observed that people who lived in Chestnut unit could not access the courtyard garden as the doors leading to this were locked. A member of staff told us, "If they (people residing in Chestnut unit) want to go outside the staff will unlock the door." The courtyard garden was fully enclosed and there was no risk of people leaving the home unnoticed if they were in the courtyard garden. Another member of staff told us that the doors were kept locked as one person who lived in Chestnut unit was at risk of falling if they attempted to access the garden area. We raised this with the registered manager who agreed that the rights of freedom of movement for people who lived in Chestnut unit should not be compromised due to the risk of falling for one person. Immediately the registered manager arranged for the door to be unlocked and a devise fitted that would allow staff to monitor people accessing this facility.

The registered manager had sought written confirmation from people who had Lasting Power of Attorney for health and welfare or financial matters issued by the Office of the Public guardian. A LPA is issued by the Office of the Public Guardian to ensure people have the legal right to act on behalf of individuals. Where necessary, copies of certificates of authorisation had been obtained.

People said that the food at the home was good and that their dietary needs were met. One person said, "They offered me omelette when I did not like the food on the menu, this was very kind of them." People had choice over their meals and were effectively supported to maintain a healthy and balanced diet. We observed the lunchtime experience and found the atmosphere in the dining room was relaxed with lots of chatter throughout the mealtime. We saw staff sat with people and offered them support to eat. People were offered plenty of fruit juices and water with their lunch. Tables were attractively set with tablecloths, napkins and condiments. Music was played in the background and fans located due to the warm weather that day.

A five week menu was in place that offered people a variety and choice of home cooked meals, desserts and snacks. We observed that the lunchtime meals provided reflected those advertised on the menu. Drinks were served throughout the day and staff were seen to offer encouragement to people to during when this was needed.

People were asked about their dietary needs and preferences. In the kitchen there was a reference board which detailed specific needs such as, diabetic, vegetarian, fork-mashable or pureed diets. When concerns about a person's ability to swallow safely were identified these were followed up. Referrals had been made to the SALT. Recommendations of food and fluid textures had been amalgamated into people's care records. If people needed aids such as plate guards, adapted cutlery or beakers to help them manage to eat and drink independently, these were accessible. Where necessary people had food and fluid charts in place to monitor their intake and care plans about their specific dietary requirements. For example, one person's plan stated that the person ate independently, but might require assistance. The plan then detailed the level of assistance. The same person was also on a soft diabetic diet and the chef knew about the person's needs.

Staff said that they were fully supported to undertake their roles and responsibilities. They received one to one supervision as well as group supervision and an annual appraisal. One member of staff said, "I have supervision every three months where I am asked if I have any troubles, if I am happy. We have a lot of training, we are forever doing it. The dementia crisis team came in and gave advice how to support people with activities, how to deal with behaviour." A second member of staff said, "Training is good. What was current best practice last year may not be this year so it's important to do refresher training."

Staff were skilled and experienced to care and support people to have a good quality of life. The registered

provider had its own training academy that managed and provided induction and training programmes for staff. New staff undertook an induction programme at the start of their employment which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. During their induction new staff also shadowed more experienced staff. Newly recruited staff confirmed that that they had shadowed other staff when they first started to work at the service which allowed them the opportunity to get to know people and what was expected of them.

A training programme was in place that helped to ensure staff knowledge was current. Training was provided in areas that included first aid, fire safety, moving and handling, health and safety and infection control. In addition, training was provided relevant to the needs of people who lived at the home. This included dementia care, equality and diversity and positive dining experiences. During our inspection training sessions took place for infection control and COSSH. Staff told us that they found the face to face training useful. Numeracy and literacy assessments and support was also provided to staff in order that they could communicate and complete records to a satisfactory standard.

People said that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively. People were supported to maintain good health and access external healthcare support as necessary. People told us that staff arranged for them to see professionals such as a GP or chiropodist as necessary. A GP visited the home on a weekly basis in addition to people being able to request to see a GP at times of their choosing. We observed the GP visit on the day of our inspection and staff showed they knew the needs of people well when talking to the GP.

Care plans considered people who lived with dementia and if they could not verbalise being in pain. They included guidance to staff to help ensure people received effective pain relief. For example, one person's plan stated 'Look for nonverbal such as facial gestures, whimpering, and loss of appetite. Use non pharmacy interventions first such as humour and relaxation, repositioning.' Staff that we spoke with were able to tell us about peoples specific communication needs without referring to records.

Good

Is the service caring?

Our findings

People said that they were treated with kindness and respect. One person said, "The staff and manager are caring." A second person said, "The staff treat us with dignity and respect." One relative said, "I could not ask for better care for my husband. They are kind."

The atmosphere in the home was calm, relaxed and friendly. It was apparent that positive, caring relationships had been developed with people. One person said, "There is a good relationship as they stop by to have a chat when they get a chance." Relatives were welcomed at the home. One relative told us, "The continuity of staff is good, even with agency they use familiar faces. It really makes a difference." A member of staff said, "One of the best things here is the atmosphere. When you come through the door its welcoming." A large colourful poster was displayed that reminded staff 'Our residents do not live in our workplace – we work in their home.'

The registered manager was seen around the home during the inspection and had a good rapport with people who lived there and staff. She had a hands-on approach and knew people individually. One person said, "Staff know me very well and management pops in frequently for a chat."

Staff understood the importance of promoting dignity, respect, independence and involvement. One member of staff said, "When washing and dressing put towels over as much of body as possible and make sure doors are shut. It's important to ask what they want, they have rights. We try and promote independence as much as we can but if struggling offer help. For example, we cut food up so they can feed themselves. But if see struggling offer help. We try and encourage to mobilise independently as using a hoist is not good if they are able to do this safely." A second member of staff said, "When giving someone a bed bath don't just take the covers off. Talk to the person and not over them. Make sure people have proper washes, that men are shaved, teeth cleaned, creams applied to skin. Report anything that's not usual for them. Make sure nutritional diet and plenty of fluids. Talk to them. Basically treat as we would want to be treated. Make sure they are happy."

Staff assisted people to have their medicines with sensitivity and respect. For example, a nurse was heard saying to one person, "Would you mind me giving you your meds? Shall I put them here for you? Have a drink to make it easier to swallow, slowly does it, thank you."

People had been supported with their personal care in order to maintain their dignity. People wore clothing that was clean and appropriate for the time of year. It was very warm on the day of our inspection. Staff had assisted people to wear hats that offered them protection from the sun when sitting in the courtyard garden. People's hair was clean and men were freshly shaved.

People's privacy was respected. People told us that staff respected their privacy. We observed that staff respected people's private space and as such they routinely knocked on people's bedroom doors and sought permission before entering. Support was provided in a discreet and caring way. Staff addressed people by their preferred name which was usually their first name.

People's bedrooms had been personalised to reflect their own interests and hobbies. People told us they had appreciated being able to bring items of their own furniture and make their rooms their own. Areas of the home were dementia orientated with reminiscence corners so people could potter and relax.

People were supported to express their views and to be involved in making decisions about their care and support. One person said, "I do feel involved, we always have a meeting about my well-being." A second person said, "I get to choose the activities I wish to engage in and where to sit during meal times and they respect the times I wish to have my meal in my own room."
Information was displayed at the entrance to the home to help people understand choices about their care. This included information on support services for people with Alzheimer's disease, transport services and legal services. Residents meeting took place and their views acted upon. For example, people who lived in Chestnut unit commented that they did not like the activity coordinator wearing uniform as they 'looked on as a worker not a friend.' They commented that they felt that they had lost a friendship. This was immediately addressed with the activity coordinator no longer wearing the uniform.

Good

Is the service responsive?

Our findings

People said that their received a responsive service. One relative said, "They keep us informed. If anything happens, straight away they are on the phone." They also told us how when their family member first moved into the home that they used a catheter but that the registered manager and staff had supported their family member so that they no longer needed the catheter. The relative said, "As a result they have less discomfort and are much happier."

People's needs were assessed and care and treatment was planned and delivered to reflect their individual care plan. Everyone had care plans in place for identified needs. These included personal care, communication, nutrition, health needs and moving and handling. We did note that the level of detail within stimulation and activity care plans was not at the same level as other care plans. This is an area for development. Despite this, people said that they were happy with the choice of activities on offer. One person said, "Staff frequently visits and have a chat when they get a chance." A second person said, "We have a lot of entertainment which keep our senses going during the day." A relative said, "The activities are excellent. The activity coordinator really tries to involve people."

During the inspection we observed people participate in a music session provided by an external entertainer who regularly visited the home. During the morning the entertainer visited people who lived in Chestnut unit and during the afternoon they provided a music session to people who lived in the main part of the home. This ensured that everyone was given the same opportunity to enjoy the activity. It was apparent that people enjoyed the activity from the smiles on their faces and how they became alert and aware of their surroundings. Many people were seen joining in with the songs.

Staff understood the importance of providing stimulation to people including those living with dementia. One member of staff said, "It's important to find out peoples likes and arrange activities that reflect or make sure their surroundings reflect their likes. For example if someone likes flowers we purchase. Put music on that they enjoy. Mornings can be busy but in the afternoon we have time to sit and have a chat with people. Activity staff do one to one time with people who are in their rooms or who are not mixing with others. It's important they are not overlooked."

Information about forthcoming activities was displayed throughout the home so that people knew in advance events that were going to take place. Activities on offer included board games, sing a longs, church services, bingo, pampering sessions, gardening and flower arranging.

People were supported to access their local community and to maintain links with people who were important to them. The home has its own mini bus that people could use to access the wider community. A trip to a local garden centre was planned for the day after our inspection. Four trips a year were planned and information about these was displayed in order to inform people of the choices available. People from the local community were also invited to activities and lunch at the home which further promoted community integration.

Some efforts had been made to make Chestnut unit stimulating for people who lived with dementia. There were memory boxes to help people orientate around the unit. However we noted some were empty. There was signage but this could be made clearer. The wallpaper in the lounge was very bold and could cause confusion to people who lived with dementia. One person said of the wallpaper, "I do not like it. It is too bright." It is recommended that the registered person implements current best practice guidance in relation to dementia friendly environments.

Staff said that communication systems were effective and records confirmed this supported responsive care. One member of staff said, "We read the care plans, talk to other colleagues, the manager and the service users themselves. Plus there are regular meetings." Daily operational meetings took place and weekly clinical nurse meetings. During these people's needs were discussed and action taken when necessary in response to changes in needs. For example, when one person started to display behaviours that could be viewed as challenging arrangements were made for the person to be seen by a CPN who reviewed their care and medicine. Nurses at the home then reviewed the persons care plan to ensure it reflected their current needs.

People said that they knew who to approach to raise concerns. One person said, "Yes, to complain I do approach staff or a manager and tell them about my concern." The person went on to say, "Staff and managers are very kind and helpful, nothing more to ask for." A visitor of one person who lived at the home told us that the person used to manage their shopping online and could operate the telephone them self. After raising this issue, management agreed to relocate the person to a room where they could have a personal house phone at their disposal. During our visit we observed staff assessing if people were happy as part of everyday routines that were taking place. A suggestions book was located at the entrance of the home that people could use to raise concerns if they did not wish to use the formal complaints process. A record was in place that confirmed comments were acted upon. For example, the fish tank at the entrance of the home had been cleaned.

The complaints procedure was displayed in the home and included the contact details of other agencies that people could talk to if they had a concern. These included the CQC. A record was in place of complaints received, investigations undertaken and the outcome of these.

Good

Is the service well-led?

Our findings

At our last inspection on 8 March 2016 we found that the provider had not ensured their CQC inspection rating was displayed as required by law. As a result a requirement action was made. In response, the registered manager submitted an action plan that detailed the steps that would be taken to address the requirement action. At this inspection we found that the requirement action had been met and that the contents of the registered manager's action plan complied with.

People said that the home was well-led by the registered manager. One person said, "The staff and managers are always available." One relative said, "X (registered manager) is very open and accommodating. She listens and is not defensive. She's incredible."

There was a positive culture at the home that was supported by a registered manager who took steps to ensure this was inclusive and empowering. Everyone that we spoke with said that the registered manager was a good role model. Staff were motivated and told us that they felt fully supported and that they received regular support and advice. One member of staff said, "This is the best home I've worked in. The manager is a nice manager, willing to help and advise and support." A second member of staff said, "She (registered manager) has the open door policy. She can be firm but its valid when she is. She's come through the ranks so understands everyone's roles. She's a fair personal and greatly respected."

The registered manager demonstrated a commitment on continually striving to improve and was open and transparent throughout our inspection. When we raised issues with her she immediately took action to address these. For example, when we informed her that a call bell was not working she had this replaced immediately. Other examples of the prompt action undertaken by the registered manager are referred to in the Safe and effective sections of this report.

The registered manager demonstrated understanding of her responsibilities and had ensured legislation was complied with. She was aware of the legal requirement to report significant events. As such, notifications were submitted to the Commission in a timely and transparent way. Information was stored securely and in accordance with data protection. The previous CQC inspection rating was on display in the home. The registered manager had completed and returned the PIR when requested. The information in the PIR was accurate and identified areas for future development. This demonstrated a commitment by the registered manager to be open and transparent about what aspects of the service she would like to improve.

Quality assurance systems were in place that helped ensure quality standards were maintained and areas for development actioned. These included audits of medicines, accidents and incidents, hospital admissions and ambulance call outs, meals, and health and safety. In addition to these assessments of the service were completed by an area manager and by independent auditors with the findings fed back to representatives of the provider. All the audits sampled showed that prompt action had been taken when areas of improvement were identified.

People's views were sought and used to drive improvements in the form of quality audit questionnaires.

People were asked their views on areas that included staff, food, the laundry, activities and infection control. When people made suggestions these were acted upon. For example, in April 2017 one person said that they would like Skype facilities to maintain contact with their family member. This was acted upon and information was displayed in the home informing people that this facility was now available to everyone. In a questionnaire completed in March 2017 a person commented that the main door to the home needed to be painted. This was acted upon and the door was seen to be freshly painted when we inspected.