Helen McArdle Care Limited

Kirkwood Court

Inspection report

Kirkwood Drive
Kenton
Newcastle Upon Tyne
NE3 3AX
Tel: 01912133690
Website: www.helenmcardlecare.co.uk

Date of inspection visit: 21 & 22 October 2015
Date of publication: 24/02/2016

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

The inspection took place on 21 and 22 October 2015 and was unannounced. This means the provider did not know we were coming. We last inspected Kirkwood Court in October 2013. At that inspection we found the service was meeting the legal requirements in force at the time.

Kirkwood Court provides personal care for up to 72 older people, including people with dementia- related conditions. Nursing care is not provided at the home. At the time of our inspection there were 63 people living at the home.

The service had a registered manager. 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. The provider informed us that the registered manager was leaving and a new manager had been appointed who would be applying for registration.

Summary of findings

People told us they felt safe at the home and with the staff who supported them. Care was provided in a clean, safe and comfortable environment. Staff were trained in safeguarding and understood how to protect people from abuse.

New staff were thoroughly vetted to make sure they were suitable to be employed. Staffing levels were determined according to the numbers and dependency of people living at the home.

People were given support to maintain their health and well-being, access health care professionals, and to take their prescribed medicines safely. A varied and balanced diet was provided to ensure people had good nutrition. Where necessary, dietetic advice was obtained and staff supported people with their eating and drinking needs.

Staff were provided with training that enabled them to care for people effectively. All staff received regular supervision to support their personal development and an annual appraisal of their work performance.

People directed the ways they wished to be supported and gave consent to their care and treatment. Formal processes were followed to uphold people's rights under mental capacity law when they were unable to make important care decisions.

Staff were caring and respectful in their approach and promoted people's privacy and dignity. They had a good understanding of people's preferences and encouraged them to make choices about their care.

People's needs and any risks were assessed and documented in individual care plans. Care was routinely reviewed and adapted when people's needs changed. A range of activities and events were provided to help people meet their social needs.

There was an open culture and people and their families were consulted about the running of the home. A complaints procedure was in place and any concerns were promptly responded to and investigated.

Appropriate management arrangements had been made to support the service and provide leadership until the new manager took up post. Standards at the home were subject to continuous monitoring to assure the quality of the service and the care that people received.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

Sufficient staff were employed to meet people's needs.

Appropriate arrangements were in place to protect people from abuse and to respond to any safeguarding concerns.

Risks to personal safety were assessed and action was taken to prevent people from being harmed.

People's prescribed medicines were administered safely.

Is the service effective?
The service was effective.

Good

Staff were trained and supported to meet people's needs effectively.

People consented to their care and had their rights under the Mental Capacity Act 2005 protected.

People were suitably supported to maintain their health and receive health care services.

People were assisted in meeting their dietary requirements.

Is the service caring?
The service was caring.

Good

People were supported by staff who were caring in their approach.

Staff respected people's rights to privacy and to be cared for in a dignified manner.

People made decisions about their care and were given information about what to expect from using the service.

Is the service responsive?
The service was responsive.

Good

A varied and stimulating range of activities was provided to help people in meeting their social needs.

Care planning was individualised and focused on each person's needs and well-being.

Complaints were taken seriously and acted upon.

Is the service well-led?
The service was well led.

Good

A new manager had been appointed who would be applying for registration.

A positive culture was promoted that encouraged people, their representatives and staff to work inclusively.

There were robust systems for checking and developing the quality of the service that people received.

Kirkwood Court

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 was 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.

The inspection took place on 21 and 22 October 2015 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist advisor and an expert-by-experience. 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During the inspection we talked with 16 people living at the home and four relatives. We spoke with the head of elderly care, the managing director, an operations manager, the provider's head of housekeeping, a support manager, the assistant manager, the administrator, an activities co-ordinator and with 11 care and ancillary staff. We observed how staff interacted with and supported people, including during a mealtime. We looked at eight people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe and comfortable living at the home. Their comments included, "I am very happy. I feel safe. I couldn't be in a better place"; "They (staff) are very good and treat us well"; and "I'm safe here, there is always someone to help." A relative said, "(Name) seems very safe here, there have never been any issues." Another relative commented on the standard of hygiene and told us, "It's a lovely place, always lovely and clean."

People were given a guide to the service which informed them about the measures in place to maintain their safety and security. This explained the service aimed to keep people safe from abuse, bullying and harassment and that staff would act immediately on any safeguarding concerns raised. People were directed to local authority safeguarding leaflets available in the home and asked to inform the manager or senior staff if they had concerns about their care or treatment. Further information was provided in the guide including details about fire safety, using the call system, informing staff when leaving the home, and keeping personal effects and valuables safe.

Comprehensive policies and procedures about safeguarding and associated topics were provided for staff to refer to. The staff we talked with understood their responsibilities in preventing abuse and knew how to report any concerns. They confirmed they had received safeguarding training and we saw evidence of this in records. A poster for the provider's whistle-blower hotline was displayed in the staff room. Staff told us they would use this facility if they ever had the need to report poor practice. One staff member told us they had raised concerns which the assistant manager was looking into.

The service had taken appropriate steps to report safeguarding allegations and co-operate with investigations. Safeguarding records were kept including the outcomes of allegations, actions to keep people safe, and any changes made to practice to prevent incidents from re-occurring.

The head of elderly care told us they were looking to introduce a policy on the provider's statutory responsibility of 'duty of candour'. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

There were safe systems for managing people's personal finances. Where people had chosen to have their money held for safekeeping, all expenditure was suitably recorded with corresponding receipts. Monthly audits and an annual finance audit had taken place to assure people their money was handled safely.

Recruitment information showed that new staff were properly checked and vetted before they started work. Application forms, with employment history and details of training and health screening were completed prior to candidates being interviewed. Proof of identity, criminal records checks, and two references, including one from the last employer, were obtained. All pre-employment checks were confirmed in a checklist to demonstrate the provider's recruitment process had been followed.

The assistant manager told us the current staffing levels were 10-11 care staff during the day and eight at night, including seniors on each shift. The operations manager showed us reports where they had reviewed the staffing levels with the registered manager each month. The levels had been determined according to the numbers of people living at the home and their dependency assessment scorings. Other factors taken into account included accidents/incidents; any complaints about care or safeguarding issues; and clinical key performance indicators for people requiring extra support.

The home had a full complement of care and ancillary staff. Any cover for absence was provided from within the existing staff team to ensure people received consistent care. There was a tiered on-call system outside of office hours for staff to get advice or support at any time and for reporting any emergency circumstances to senior management. There was also evidence that the management did regular spot checks of the home during the night and at weekends to check that people were being safely cared for at these times.

During our visit we saw care staff worked at a steady pace, did not appear over stretched, and responded promptly to people's requests. The staff we talked with had no concerns about the staffing levels.

One person living at the home told us they thought there was a high turnover of staff. They said, "Staff changes unsettle the residents." A relative told us that although staff were very caring, they felt they only came into their family member's bedroom at meal times or to serve drinks. One

Good

Is the service safe?

person living at the home commented, “They (staff) don’t talk to me very much, they are so busy.” Another person told us the staff did not come into their bedroom very often, and if they called for help they had to wait a while before anyone came. This person spent time in their bedroom (on the second floor), had mobility difficulties and did not have their alarm call within reach.

We followed up people’s comments with the management. We were informed seven care staff had left in the past year, one of whom had returned to the home, and this was not felt to be a significant turnover given the size of the staff team. The staffing report for the previous month indicated care staff numbers for the ground floor during the day had recently been increased. The head of elderly care told us seniors were expected to organise staff to make sure they supervised people in and around communal areas and to carry out hourly ‘comfort checks’ on individuals. We were shown logs of the call system which demonstrated that staff response times averaged less than a minute when people summoned assistance during the day and at night. We concluded that there were sufficient staff available to ensure people’s needs were met.

Care records showed risks to people’s personal safety had been assessed. Measures were in place to reduce identified risks such as moving and handling, falls, skin integrity, sensory impairments and specific medical conditions. Aids and equipment, including chair and bed sensors and pressure-relieving mattresses were provided to enable people’s care to be delivered safely. Individual plans were also devised to support people in the event of an emergency where they needed to be evacuated from the home.

The head of housekeeping was carrying out a bi-monthly audit during our visit. They told us these were done in line with the high environmental standards set by the provider.

We saw the audit covered all aspects of the environment in detail, including checks of maintenance and identifying where furnishings, floor coverings and equipment needed to be replaced. The audits were linked to the operation manager’s quality checks to ensure any issues were actioned within the stated timescales. Monthly internal audits were also conducted of health and safety, the kitchen, housekeeping, and infection control to make sure people were being cared for in a safe and hygienic environment.

There was robust reporting and analysing of accidents and incidents. A monthly analysis was done to check any emerging themes and ensure follow up action had been taken. For example, making referral to a specialist falls team to get support for a person who had a higher risk of falling.

There were suitable arrangements for ordering and storing people’s medicines. Senior care staff administered medicines and they were trained and had their competency in handling medicines thoroughly assessed annually. Medicines were listed in care records along with specific requirements, such as administration guidelines for a person who needed their medicines to be given covertly (disguised in food or drinks).

We checked a sample of medicine administration records (MARs) which confirmed medicines had been given as prescribed and at the correct times. However, it was difficult to decipher a clear audit trail of some people’s medicines as they had not been recorded in a chronological sequence when their MARs had run out and no further copies were available. Action was being taken to align these people’s medicines into the monthly medicines cycle and staff were following up the MARs issue with the supplying pharmacy.

Good

Is the service effective?

Our findings

The staff we talked with had a sound knowledge of the people they cared for and gave clear accounts of how they met their needs. They told us they received good support in fulfilling their responsibilities, were given a range of training, and had regular supervision and meetings. Their comments included, "I think the care here is very good and there's lots of checks and audits"; "I really love my work and learning about people is so interesting"; "We get plenty of training. I did moving and handling this week at the training academy with practical elements and role play of using the equipment"; and, "I'm very happy working here, I love the job and the people."

Staff confirmed they had received induction, including training in safe working practices, to prepare them for their roles when they began working at the home. The provider had established their own training academy earlier in 2015 that was overseen by a training manager. A training programme was in place, with over 50% of courses provided at the academy and the remainder mainly through e-learning. A training matrix was kept that gave an overview of all training completed by the staff team with dates and where courses had been organised. This showed that most staff had completed mandatory training in fire safety, moving and handling, health and safety, safeguarding, first aid and infection control. Courses were arranged for those staff who needed to refresh their knowledge in these training topics.

The majority of care staff had completed training in caring for people with dementia and challenging behaviours, equality and diversity, and mental capacity law. However, statistics for other areas of care-related training, in line with the provider's expectations, were variable. This was highlighted in quality checks by the operations manager and staff told us they had been given timescales to complete outstanding training. The management confirmed that completion of training was being given priority and additional resources had been made available to ensure staff brought their e-learning up to date. 67% of the care staff had achieved nationally recognised care qualifications and 21% were currently studying to gain qualifications.

There was a delegated system for supervising staff. A schedule was in place that showed staff received six individual supervision sessions a year and annual appraisals. A senior told us they felt confident in providing supervisions to care staff and were given some supernumerary time in which to carry out the duties they were responsible for.

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).

We checked whether the service was working within the principles of the MCA. Policies and procedures on the MCA and DoLS were available for guidance in the home. In practice, we observed that staff sought permission before carrying out any care and gave people time to make decisions. Care records contained forms which showed people had given consent to their care and treatment and care plans around choice and capacity. Records also specified where relatives had legal status such as power of attorney to make decisions on their behalf with regard to health and welfare. We found assessments of mental capacity had been carried out, and where appropriate, decisions were made in people's best interests. These included decisions in relation to providing personal care and administering medicines to maintain people's welfare. Formal processes had been followed to seek authorisation for DoLS for a number of people living at the home.

Nutritional assessments were completed monthly to identify people's needs. Care plans were drawn up for meeting people's dietary requirements and any risks, such as poor appetite or unexpected weight loss. Weights and food and fluid intake were monitored and, where needed, people were referred to dieticians for further assessment and advice. This information was provided to the catering staff to keep them informed about those people who were nutritionally at risk. We were told the chef was working with a family to provide culturally appropriate meals for their relative and had researched menus on the internet.

Good

Is the service effective?

We saw a balanced diet was provided and people were given choices at each meal. Special diets were catered for and drinks and snacks were served between meals. Where needed, people were assisted with eating and drinking and some people used adapted crockery to help them eat independently. Most of the people we talked with told us they liked the food. Their comments included, "It's all good, I eat everything and have a good breakfast", "I'm well fed"; and, "I like most things but particularly enjoy the soup, which I think is always home-made." One person commented, "The meals are not so good, the vegetables are over cooked." A relative told us they felt there were good food choices and said that the meals always looked nice.

A relative told us, "Since (my relative) came to live here, their health has improved vastly." A person living at the home told us they had been offered and agreed to have an influenza vaccination but said they had not been informed when this would be given. The assistant manager was asked to check and follow this up with the person.

Care records showed people accessed a range of health care professionals to help meet their physical and mental health needs. There was evidence of input from GP's and community nurses and regular appointments with opticians, chiropodists, dentists and for hearing tests. Information had been gathered about people's medical history and their preferred choices of visiting professionals. Health needs were care planned and supplementary guidance was made available to staff on how best to support people with particular medical conditions.

During our visit we received feedback from professionals in the challenging behaviour team about communication between staff. They told us that information the team needed was not always passed on from one shift to the other, such as completing behaviour charts and having urine and blood tests carried out. They had reported these issues to the manager on several occasions but felt there had not been any improvement. They said the staff were friendly and caring and they had no other concerns about the care provided. We relayed their comments to the management team to follow up and resolve.

Reassessments were carried out when people's health deteriorated and their needs could no longer be met. We were told these had led to some people being transferred from the home to nursing care settings.

Some people living at the home had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions in place. Where applicable, such decisions had been made in consultation with GPs and other professionals, family members and senior staff. Supporting documentation was up to date. Care records were colour coded to denote where people had DNACPR orders to enable staff in an emergency situation to readily identify whether resuscitation was required.

Good

Is the service caring?

Our findings

People living at the home and their relatives told us they felt the staff were caring. Their comments included, "The girls are all very nice to me"; "I'm happy here. The staff are kind and friendly"; "The staff are lovely"; and, "The staff are very caring." One relative told us, "I often come in and find a member of staff doing crosswords or similar activities with my (relative)."

We saw people were given, and had access to, a range of information about the service. They were provided with a 'resident's directory', an informative guide that explained what to expect from living at the home. Information about advocacy services, menus, and activities and events were displayed for reference. A monthly newsletter was also produced with updates about what was going on in the home and the provider's news and developments.

People's feedback about the service was obtained through 'resident and relative' meetings, surveys, and a comments box was available. We saw comments had been noted at the last meeting including, "Staff have been excellent when caring for my dad", and, "No complaints, on the contrary I'm treated with dignity. We have wonderful staff with lots of patience."

New people were asked to complete a short survey about their admission experience. This included their first impressions, who they were introduced to, and whether they had been informed about different areas of the service. They were asked to rate their overall experience and give any comments on how the admission process could be improved.

The staff we talked with gave clear accounts of the ways they met people's needs and how individual's preferred to be supported. For example, care staff described in detail how they supported a person with a sensory impairment to safely move around the home and retain their independence in eating and drinking. A senior explained to us the care given to a person who was due to move on from the home in the near future. This person's records confirmed they had appropriate care plans and equipment for meeting their needs in the interim. Two staff also told us the management had used an external care agency to supplement staffing to ensure another person's needs could be met until they had transferred to another care service.

We observed that staff talked respectfully to people and engaged with them. For instance, on entering the home we saw the activities co-ordinator was sat with people in the reception area, reading out to them from a newspaper, and there was lively discussion about the day's news. One person in the area was waiting to go out to a health appointment and we heard staff gently reassuring them as they were becoming anxious.

On another occasion we saw a housekeeper interacting nicely with a person, having a conversation with them about the knitting they were doing. After lunch we saw two people chose to stay in the dining room looking out of the window and a care assistant talked with them about 'blackberry week' (referring to a school term holiday). This was a phrase they recognised and it triggered a conversation where they recalled some memories of this time. The care assistant was warm in their approach, listened and showed interest in what the people were saying.

We spoke with one of the home's 'dignity champions' who was enthusiastic about their role. They told us they observed and directed staff to ensure they provided dignified and compassionate care. The management also routinely carried out observational sessions of people's care experiences. These included checks on people's appearance and comfort, care practices, and staff interactions and communication with people.

We observed that staff promoted privacy and dignity. People were able to choose where they spent their time and some people told us they preferred to stay in their bedrooms. Some people had also chosen to have keys to their rooms. We saw staff assisted people to the toilet discreetly and that a care assistant sensitively guided a person who was wearing short nightwear to their room to get dressed.

The care environment was tastefully decorated and furnished and there was a warm and homely atmosphere. Some people commented positively to us about their personal accommodation, telling us their bedrooms were "lovely". Calming music was played and there were televisions, books and games available. The gardens were enclosed and well-maintained and many rooms had views across the gardens or over the main street.

On the Grace unit, for people living with dementia, there was signage to help identify rooms, such as bathrooms and

Good

Is the service caring?

toilets, and memory themes in the corridors and lounges. We saw that a display board had the incorrect date on and Halloween decorations were covering the visibility of a large clock. We also noted there were no wall rails leading to a set of double doors, which could mean people who needed such support might have difficulty getting to this area.

At lunchtime we observed that people chose whether to eat in the dining rooms or in their bedrooms. The meals looked appetising and were attractively presented, and staff offered alternatives and extra portions. People were encouraged to eat and drink and were given choices of meals and hot and cold drinks. For example, a care assistant offered and showed a person the choices of cakes for dessert and staff asked people if they would like their drinks refilled. Where people needed assistance this was done discreetly and staff interacted with people without being intrusive. The mealtime was a pleasant experience and staff worked well as a team to serve meals and ensure people received the support they needed.

Good

Is the service responsive?

Our findings

The people and relatives we talked with were happy with the care provided at the home. They were aware of how to make a complaint, though some relatives gave us variable feedback about how complaints were dealt with. For example, one relative told us they had raised matters around attention to detail with their family member's care and said these had been appropriately resolved. They commented, "They never sweep anything under the carpet." However, a relative who had previously made complaints about laundry and health care told us they were not happy with the outcomes. Another relative told us they had paid to have their family member's clothing marked with their room number and said, "Her clothes just keep going missing and I know we will never get them back."

We checked a sample of complaints logged over the past year and saw they had been responded to promptly and thoroughly investigated. There was evidence of response letters and meetings with people who had made complaints and follow up action such as discussion with staff about care practices. A monthly summary was kept which noted the nature of any complaints received; how they were investigated; whether practices had been changed as a result; and identifying if complaints were linked to safeguarding issues.

Many compliments about the service had been received. For instance, a person had recently reviewed the home on a care homes website and rated the overall standard of the service as excellent. A number of cards and letters had also been received from relatives thanking staff for the care and kindness shown to their family members.

Pre-admission assessments were carried out to establish people's needs could be met before they moved into the home. Thereafter a range of assessments were completed each month that identified each person's current needs and dependency. Care plans were in place which addressed all needs identified from the assessments and any associated risks in providing the person's care. The care plans described the person's preferences and set out the level of care and support they required from staff. The plans were evaluated monthly to review progress and were updated when people's needs had changed. The records showed that people and their families were consulted about care planning and took part in care reviews. A relative told us, "I've seen and been involved in my (family member's) care plans."

Care records contained life story information which had been compiled with people and their families. This enabled staff to have an understanding of the person's background and history and their likes, dislikes and interests. The activities co-ordinator told us they had attended a training day on 'one page profiles' and had completed these for almost all people living on the Grace unit. We saw these profiles gave a good overview of the individual's preferences, including 'what others admire about me', 'what is important to me', and 'how best to support me'. People also had care plans for their social needs and interests and for supporting their inclusion in the community.

Staff reported on each person's well-being and the care they had been given during the day and at night. The staff we talked with told us there was good communication about people's care needs. A half hour overlap was built in between shifts for handovers of information. The handovers detailed any significant events such as health appointments, visits from doctors and nurses and gave a summary of each person's well-being across the day and night. Staff maintained communication books on each floor and completed a daily report for the person in charge of the home. All issues reported on were followed up to make sure the necessary action had been taken and, where applicable, that care records were updated.

The service had recently celebrated its' 5th anniversary with social events involving people using the service, their visitors and staff. The home employed an activities co-ordinator who took responsibility for organising activities, events and outings. The co-ordinator told us they attended training events and meetings with their peers from the provider's other care services to share ideas and practices. 'Daily activities and interaction records' were kept for each person, demonstrating the activities they had taken part in. However, although these were completed by the co-ordinator, they were not being completed by care staff to properly reflect all of the activities undertaken. A file with photographs was made available for people and their visitors to look through and see the activities and events which had taken place.

Good

Is the service responsive?

The co-ordinator was given an annual budget for activities that they supplemented at times through fundraising events. The home had weekly use of a mini-bus for outings and the co-ordinator told us they tried to ensure that everyone was given opportunities to go out. Programmes of activities were well publicised around the home on noticeboards for people's information. The current programme included a Halloween party with a magician and a 'spooky' buffet, visiting singers and an arts and crafts session. Activities suited to the needs of people living with dementia were provided and there was a regular club with activities specifically for the gentlemen living at the home. During our visits we observed a variety of group and individual activities took place which people enjoyed. A relative we spoke with praised the work of the activities co-ordinator and told us, "(Name) is a star."

We saw the co-ordinator evaluated sessional activities, reviewing the benefits and what people had and had not enjoyed. They told us that 'Life Song', a therapeutic musical gathering connecting people through music and poetry, had been of particular benefit in engaging people and was now carried out twice weekly. People were encouraged to be involved in contributing to the local community, such as a recent project about World War 2 with local primary school pupils, and knitting blankets for an animal shelter charity. Work was also ongoing on a 'three wishes' campaign, where people were asked to make wishes about what was important to them. Records and photographs were kept to capture where people's wishes had been fulfilled. We were shown examples, including therapy ponies being brought into the home for a person who wanted to interact with horses, and a person's 100th birthday party appearing in the local newspaper. We found there was a good level of activities that provided stimulation for people and helped them meet their social needs.

Good

Is the service well-led?

Our findings

At the time of the inspection the registered manager was leaving the service. Interim management arrangements had been made and senior management were providing input and support to the home. The head of elderly care told us a new manager had been appointed and they would take up post in the near future and apply for registration.

The home had a clearly defined management and staffing structure and senior care staff were allocated to lead all shifts. There were also 'heads of department' who were accountable for different aspects of the service including housekeeping and catering. Meetings were held with all grades of staff to discuss their roles, responsibilities and practices and employment issues. Recent meetings had included updates on management and staffing; confirming staff's understanding of specific policies; and a reminder about the availability of the provider's employee assistance programme. The provider also arranged rewards and discounts for staff and held recognition award events.

Staff's views had been sought in an employee survey carried out in 2014. This was conducted with new staff employed across the company and findings showed good results about feeling valued, respect for senior managers, loyalty, induction and mentoring. The staff we talked with gave positive feedback about support in their roles and team work. For instance a senior worker told us they were given some supernumerary time for their responsibilities including care planning and ordering and receipt of medicines. Other comments included, "The company values its staff"; "Senior managers are good and approachable"; "I feel I'm a valued member of staff"; and, "We work as a team and cover for each other for holidays and sickness."

'Resident and relative' meetings were held to involve people and their representatives in the running of the home. The meetings followed a protocol with reports given by the manager, activities co-ordinator, chef and housekeeper. People gave their views about the service at these meetings, though one person told us, "We can put forward our complaints and suggestions but they are not often carried through."

People were also able to give their feedback about the service by completing surveys. The findings from these, and the action taken in response, were displayed so people could see how their comments had influenced the service. For example, findings from surveys done by a market research organisation had highlighted issues about the food and staff communication and interaction with people. In response more variety and specific requests for meals had been incorporated into the menus and management were completing extra observations of people's care experiences.

The home's own survey for 2015 showed the vast majority of respondents had rated that they strongly agreed or agreed with all questions about the care provided, staff approach and recommending the home to others. Responses about food at the home were variable so a separate food satisfaction survey had been conducted. The provider's catering manager and the operations manager also periodically observed meal times, sampled the food and asked people for their comments about the meals.

A survey for professionals had been conducted in 2015 with GP's, district nurses and other health and social care professionals who had contact with the home. The findings showed very positive outcomes around their confidence in the staff, their approachability and working relationships with the home. Local Authority Commissioners told us they had recently spot checked the home and found no issues of concern.

The managing director told us trials of electronic care planning and medicines management were taking place with a view to being rolled out across the provider's care services. The head of elderly care told us about the vision for the future of the service and other developments. They said it was important that the new manager was embedded into the home and supported to understand the company's standards. A pathway for staff to further their careers had been developed and there were plans to provide more bespoke training according to roles and the needs of people cared for at the home. Further training was planned for staff on delivering the HEARTS process (a combination of therapeutic approaches that aims to enhance people's relaxation, peace and well-being) and to implement this with people living at the home. All managers within the company had been given a presentation specific to caring for people living with dementia. This was intended to be cascaded to relatives either at a meeting or a separate event to enhance their understanding.

Good

Is the service well-led?

A range of audits and checks were undertaken to monitor standards at the home. These covered various aspects of the service such as care records, medicines, housekeeping, infection control and health and safety. The manager submitted a monthly report to their area manager to keep them appraised of significant events, including any safeguarding alerts and complaints, and action taken in response to specific care issues. The operations manager carried out comprehensive bi-monthly audits and visited the home in between these times, often unannounced.

Their audits included direct feedback from people living at the home and staff and checking the progress of areas identified for improvement. The last audit completed in September 2015 had resulted in a number of action plans with set timescales for improvements to be made. There was evidence that some issues had been followed up immediately and other areas were in the process of being completed. This showed us the management was proactive in continuously monitoring the quality of the service.