Life Style Care (2011) plc

Eltandia Hall Care Centre

Inspection report

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Date of inspection visit: 30 and 31 July 2014
Date of publication: 09/02/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This inspection was unannounced. At our previous inspection in October 2013, we judged that the service was meeting all the standards we inspected.

Eltandia Hall Care Centre provides care and support for up to 83 people and at the time of our visit, 70 people were using the service. It has two residential units on the first floor and two units offering nursing care on the ground floor. Three of the units provide care for older people and one unit provides nursing care for younger adults with physical disabilities. The service has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

People felt safe using the service and there were arrangements in place to safeguard people from abuse. Staff were aware of the requirements of the Mental

Summary of findings

Capacity Act and the Deprivation of Liberty Safeguards (DoLS), which care homes are required to meet. The service acted within legal requirements when determining whether people needed to be deprived of their liberty to keep them safe.

People had individual risk assessments detailing the risks to their health and safety, based on assessments of their needs. Staff were familiar with risks relating to people and what measures were in place to keep them safe whilst promoting their independence.

People and their relatives felt there were enough staff to keep people safe and robust recruitment procedures were in place so that only suitable staff were recruited. Staff were visible in communal areas and attending to people's needs in a timely manner.

People received effective care from staff who were appropriately trained. The service sought specialist guidance on best practice. The service took action to address gaps in the specialist knowledge of staff. Staff had regular supervision to ensure they were delivering consistent, evidence-based care.

People were supported to have a choice of enough suitable food and fluids to meet their needs, including cultural needs. Staff ensured that people drank plenty of fluids in hot weather and people at risk of malnutrition were monitored.

People were supported to access healthcare professionals when they needed to and they were regularly visited by dentists and chiropodists. People were able to access specialist services if they needed to.

The home was adapted to meet the needs of people using the service, including people who used wheelchairs or other mobility equipment. There was information displayed, which was designed to meet the needs of people living with dementia. We found that the home was in need of refurbishment, although it was fit for purpose.

People and their relatives had positive relationships with staff. Staff understood and responded to people's diverse individual needs and were familiar with their histories, preferences and routines. Staff interacted with people in a caring manner and respected their privacy, dignity and independence. There was a 'dignity champion' who shared information on specialist guidance and best practice to staff. The service worked with experts to promote the dignity of people living with dementia. People were involved in decisions about their care and support and this involvement was tailored to people's individual communication needs.

The home used specialist guidance to ensure that when people were dying they had a comfortable and dignified death. They worked with a palliative care team, doctors and with people and their families. However, end of life care plans were not filled in and so there was a risk that people's end of life wishes might not be carried out because the information was not available.

People's care was planned and delivered in accordance with their individual needs gathered at assessment and regularly reviewed with people to reflect their changing needs. The service promoted diversity and held cultural celebrations to help ensure that everyone felt included. The service promoted community involvement and encouraged contact with family and friends. A variety of activities and outings was provided, although the activities on offer did not suit everybody who used the service.

There was an accessible complaints procedure and the service responded appropriately to people's concerns and complaints. People who used the service knew how to complain and felt their concerns were listened to, although some people did not know whom to report concerns to.

Leadership was visible and the manager had an 'open door' policy. People knew who the manager was and had a friendly relationship with them. Staff felt supported by managers and were able to raise concerns and ideas. Achievements of staff and people who used the service were celebrated. The home used surveys and meetings to gather people's views and improve the service, but some people did not have the opportunity to be involved in developing the service.

The service had mechanisms to measure and monitor the quality of the service and learn from accidents and incidents. Action was taken promptly to address shortfalls in the safety or quality of the service so there was a focus on maintaining high quality care.

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. People felt safe using the service and there were arrangements in place to safeguard people from abuse. The service acted within legal requirements when determining whether people needed to be deprived of their liberty to keep them safe.

The service assessed risks to each person on an individual basis and staff knew what measures were in place to reduce these whilst promoting people's independence.

There were enough staff to keep people safe and robust recruitment procedures were in place so that only suitable staff were recruited.

Is the service effective?

Good

People received effective care from staff who were appropriately trained and supported in line with best practice guidance. The service took action to address gaps in the specialist knowledge of staff.

People were supported to have a choice of enough suitable food and fluids to meet their needs and people at risk of malnutrition were monitored.

People's needs were met in terms of accessing healthcare professionals and adaptations to the environment. The home was in need of some refurbishment but was fit for purpose.

Is the service caring?

Requires Improvement

The service was not consistently caring because information about people's end of life wishes was not recorded. This meant there was a risk that people's wishes might not be carried out. The home used specialist guidance to ensure that when people were at the end stage of life, they had a comfortable and dignified death.

People and their relatives had positive relationships with staff, who understood people's diverse individual needs. Staff interacted with people in a caring manner and respected their independence.

The service placed a focus on maintaining people's dignity and privacy and worked with dementia experts to promote the dignity of people living with dementia. People were involved in decisions about their care and support.

Is the service responsive?

Good

The service was responsive. People's care was planned, delivered and reviewed with people in accordance with their individual and changing needs.

Summary of findings

The service promoted community involvement and encouraged contact with family and friends to protect people from social isolation. A variety of activities and outings was provided, although the activities on offer did not suit everybody who used the service.

People who used the service knew how to complain and felt their concerns were listened to, although some people did not know whom to report concerns to. The service acted promptly in response to concerns that people raised.

Is the service well-led?

Good

The service was well-led. Leadership was visible and the manager had an 'open door' policy. The home used surveys and meetings to gather people's views and improve the service, but some people did not have the opportunity to be involved in developing the service.

The service had mechanisms to measure and monitor the quality of the service and learn from accidents and incidents. Action was taken promptly to address shortfalls in the safety or quality of the service.

Eltandia Hall Care Centre

Detailed findings

Background to this inspection

The inspection team consisted of an inspector 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 we visited, we reviewed the information we held about the service including a provider information return (PIR), which we asked the home to submit. This is a form that asks the provider to give some key information about its service, how it is meeting the five questions, and what improvements they plan to make. We reviewed reports from Age Concern Dignity in Care visits. We also looked at previous inspection reports. At our last inspection in October 2013, the service was judged to be meeting all the standards inspected.

At this visit, we spoke with sixteen people who used the service and two visitors of people who used the service, nine care staff, the chef and the registered manager. We observed care being carried out and we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We used pathway tracking, which means looking at how the service works with people from before they start using the service through to the present or the end of their care package. We looked at five people's care plans and also reviewed five staff files. We looked at other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the home. One person said, "I feel safer than where I've come from." Staff had training in safeguarding adults and this was refreshed as part of the home's ongoing training programme. Leaflets on safeguarding people from abuse were available to support people and their relatives with information about how to recognise and report abuse. Staff we spoke with were also aware of how to recognise and report abuse in accordance with the home's safeguarding policy and procedure.

Staff told us how they would manage behaviour which challenges others. This included giving people space and speaking to them in a calm manner. Staff said they would not use restraint. These techniques helped to ensure that people's safety and dignity were respected in challenging situations.

Staff we spoke with knew about the Mental Capacity Act 2005 and how it should be used to protect people's rights. For example, they were familiar with the procedures that should be followed when a decision had to be made on behalf of a person who did not have the capacity to consent. This included keeping appropriate records, the involvement of social workers and others involved in the person's care and family if appropriate and holding discussions to ensure that decisions made on people's behalf were done so in their best interests.

Care homes are required by law to comply with the Deprivation of Liberty Safeguards (DoLS), which form part of the Mental Capacity Act 2005 and state that no person should be deprived of their liberty except as a last resort. The home had appropriate policies and procedures in relation to this. During our visit, the registered manager explained that they had sent DoLS applications to the local authority in respect of 19 people living in one of the units, which was kept locked with a keypad on the exit doors. This was to protect people living with dementia who had been assessed as being at risk of coming to harm through wandering or becoming lost. Some of the applications were approved during our visit and the manager sent the appropriate notifications to CQC as required. This showed that the provider was acting within the requirements of the law in relation to protecting the rights of people whose liberty needed to be restricted to manage risks to them. The service used a DoLS screening tool supplied by the local authority, carried out assessments to check whether people had the mental capacity to agree to their liberty being restricted, and consulted independent mental capacity advocates (IMCAs) where appropriate. There was evidence in people's files that other professionals involved in their care had taken part in meetings to discuss whether people's liberty needed to be restricted.

We saw posters displayed throughout the home reminding people to call for staff if they needed help rather than try to move themselves if they were at risk of falls. Each person had a moving and handling needs assessment before they began using the service. This helped the service to identify how best to promote people's independence, for example by use of mobility equipment, whilst managing risks in terms of falling or incorrect handling. Some people invited us to see their bedrooms and we saw that each person had a call bell within reach of their bed so they could summon help if needed. We noticed during our visit that a carpet in one person's bedroom was torn and presented a risk that somebody could trip on it and fall. However, when we reported this to the home manager, they immediately contacted senior management to request a new carpet and we saw evidence the request had been approved the following day.

Each person had an individual risk assessment based on their initial assessment and ongoing reviews. These included risks to the person's health caused by existing conditions and other factors such as nutrition, falls, moving and handling and risks caused by side-effects of medicines people were taking. The assessments included details of what the risks were and what actions staff should take to minimise them. Assessments that we saw had been updated after incidents and new preventative measures were put in place. Staff we spoke to were able to give examples corresponding with what we found in risk assessments, showing that staff were well informed about the risks to people and how to protect them from harm. However, we also noted that risk ratings in the assessments all gave maximum severity and likelihood ratings for each risk. This did not match the information given and the assessments did not show how risk management plans reduced the likelihood or severity of the risks. Without this information, there was a risk that staff might err too much on the side of caution when managing risks, causing people's independence to be compromised. We spoke with the registered manager, who told us they would ensure that risk ratings were accurate in all of the files.

Good

Is the service safe?

Staff were trained in responding to emergencies and each person had a coloured sticker on their bedroom door corresponding to the level of support they needed to evacuate the home in an emergency. This helped staff to ensure that they could safely support people to leave the home in the event of fire or other emergency.

People told us they felt there were enough staff and that when help was needed they did not usually wait unreasonable lengths of time for assistance. We observed during our visit that staff were visible in communal areas and there were enough staff to tend to people's needs without them having to wait a long time for assistance. The registered manager told us the organisation had an agreed staffing level of one member of staff per five people, but this was flexible. They told us they were allowed to put more staff on the rota if a needs analysis showed it was necessary to meet people's needs. Staff confirmed they moved between the units to provide extra cover where necessary. One member of staff felt there was often a shortage of staff and they did not always feel people were safe. However, eight other staff we spoke with said there were enough staff and risks were managed well.

We checked five staff files and found the provider had carried out appropriate checks to protect people from the risks of being cared for by unsuitable staff. These included proof of identity and right to work in the UK, references from previous employers, criminal record checks, copies of certificates and checks on employment history.

Good

Is the service effective?

Our findings

People told us they received effective care. One person said, "I've got a care plan. I'm not worried as my needs are well met and staff know what's needed." We saw evidence the service sought expert advice and staff received training in caring for people living with dementia. There was a 'dementia champion' who told us they attended regular study days and brought back information on up-to-date research and practice to share with the team. Staff meeting records showed that one example of an idea they had brought to a team was a 'resident of the day' scheme to ensure each person had the opportunity to have treats and outings of their choice.

The home used a number of standardised evidence-based tools to assess people's needs, such as the Malnutrition Universal Screening Tool (MUST) and the Waterlow pressure sore risk assessment.

One person said, "The staff are very good; they are highly trained." Staff told us they were happy with the quality of their training. The service employed a member of staff who was a qualified trainer and moving and handling risk assessor. The trainer told us their mandatory training programme was based on Skills for Care national minimum training standards for care homes. Rotas confirmed the trainer also worked shifts alongside staff and they told us they observed staff, particularly new staff, to ensure they were working in line with best practice and so they could immediately address any poor practice with staff. They gave an example of a time they had arranged an extra moving and handling training session for staff after unsafe practice had been observed.

The service had a training plan, which was up to date and included training relevant to people who were using the service, such as pressure area care, dementia awareness, nutrition and managing challenging behaviour. We noted staff did not have specialist training in some areas relevant to people who used the service, such as learning disabilities or diabetes. However, when we fed back to the registered manager that this may mean staff lacked the necessary specialist knowledge to meet some people's needs, they immediately identified and booked suitable training for staff.

Staff told us they were supported to develop their skills through appraisals and opportunities to work towards further relevant qualifications. This helped to ensure staff were equipped with the necessary knowledge and skills to care for people effectively. Staff told us they had regular supervision and this gave them the support they needed to do their jobs well. Records we saw demonstrated that supervisors discussed topics with staff such as how to recognise and prevent choking at mealtimes, risk assessments and keeping people safe.

When we arrived in one part of the home, staff were offering people a choice of cold drinks. The weather was warm and staff checked to make sure people had their drinks. They offered further hot or cold drinks at regular intervals. Water and biscuits were available throughout the day in the living room.

We saw monitoring tools in people's files, where staff kept a record of people's food and fluid intake. Where these had showed that one person did not have enough fluid during the night, staff had discussed this at a team meeting to ensure all staff were aware that the person needed to be prompted to drink.

The menu for the day was displayed and there was a choice of two different meals including a vegetarian option. We looked at a sample of menus from the home and saw they offered a variety of nutritious food that was appropriate to people's cultural needs including Asian and Afro-Carribean options. Staff told us they offered a selection of breakfasts such as cooked breakfasts, porridge and cereals and they asked each person what they wanted daily. When people were eating their main meal, we observed staff discreetly encouraging people to eat their food. They explained that some people who were at risk of malnutrition needed prompting to make sure they had enough to eat. We saw evidence in staff meeting records that people's needs were discussed and the service took people's routines into consideration when planning mealtimes.

People we spoke with were aware of healthcare services they could access. People's assessments outlined their ongoing healthcare needs and how they should be supported to meet them. There was information about how much support or encouragement people needed to maintain oral care and personal hygiene. People's health was monitored and reviewed so that unmet health needs could be identified and referrals made to specialist teams when required, such as urology. Staff we spoke with told us that a doctor's appointment had been arranged that

Good

Is the service effective?

morning for one person after staff discussed a change in their presentation at handover. We saw evidence that health needs and referrals had been discussed at a night staff meeting the week before our visit.

The service kept records of people's appointments with health professionals and there was evidence that, where appropriate, doctors and other professionals had been involved in agreeing care plans around people's specific healthcare needs. People with complex health needs had 'GP care plans' developed with their doctors. People whose records we reviewed had seen doctors, dentists and chiropodists within the last six months. We saw records of a meeting the service had held with doctors earlier in the year to discuss evidence-based interventions and how to use and record these.

The home had a sensory room containing equipment designed to provide stimulation for people who were unable to express themselves verbally. Staff told us people regularly used the room, although it was not in use during our visit. We saw that part of the home, which specialised in caring for people living with dementia, was equipped with information boards to assist people with orientation. This included a board telling people what date and day it was and a staff photo board with names to help people identify the staff who were on duty.

We noted that some toilet facilities such as hand towel dispensers and grab rails were not placed within reach of people who used wheelchairs. However, when we informed the home manager of this, they took action to address the problem and the items had been moved to a more appropriate height when we returned the following day.

The home had wide corridors and lifts between floors to facilitate movement for people who required mobility equipment such as wheelchairs or walking frames. The home was spacious and had a variety of rooms for people to spend time in. Some of the home's décor was faded and looked dated. Staff told us they were concerned about the armchairs being old and having rough surfaces as they felt this presented a risk to people's dignity and could damage people's skin. The manager told us the provider had plans to refurbish the home and replace furniture but had not specified when.

Requires Improvement

Is the service caring?

Our findings

People said staff, including night staff, were very kind and told us, "I think we're very well cared for" and, "It is lovely here. If I'm honest, I couldn't be in a better place." One person told us they had developed close relationships with other people who used the service.

Staff received training in end of life care and the home used the Gold Standards Framework, an evidence-based national training programme in end of life care. Staff told us the main focus at the end of people's lives was on keeping them comfortable, being there to make sure they had everything they wanted and maintaining people's dignity by keeping them clean and presentable.

People had Do Not Attempt Resuscitation (DNAR) forms and advance care plan templates on file, but we noted these had not been filled in. Therefore there were no records of people's expressed preferences and choices or that their relatives had been involved regarding end of life care. Staff told us they discussed people's wishes with them, or with their family if the person lacked the capacity to discuss their end of life wishes, but acknowledged that people often found it difficult to talk about dying. Advance care planning is an essential part of end of life care and of the Gold Standards Framework as it 'enables a more proactive approach, and ensures that it is more likely that the right thing happens at the right time' for the person (http://www.goldstandardsframework.org.uk/cd-content/uploads/files/Library%2C%20Tools%20%26%20resources/ACP%20General%20July%202013.v21.pdf). Therefore there was a risk that people might not be treated according to their wishes or their family's wishes at the end of their lives. We discussed this with the manager, who told us they would seek advice and appropriate resources to address the issue.

The home had links with a palliative care team who came into the home to visit people. We heard the staff ensured people who became confined to their bedrooms did not become isolated and that they received visits from other people who used the service if they wished to. Staff said they visited people who were confined to their bedrooms to speak to them and ensure they were comfortable every 15 minutes. Nursing staff were aware of the importance of pain control in end of life care and told us they discussed this with people's GPs as soon as they suspected people were approaching the end of their lives.

When we arrived in one part of the home, people were sitting in a communal living room and there was music playing. Staff were singing and dancing and encouraging people to join in. We saw that people were smiling, laughing, clapping their hands and tapping their feet in time with the music. Some people had chosen not to participate and were reading books, chatting with other people or sharing jokes with staff. This demonstrated that staff had positive relationships with people, who were able to choose their level of participation in activities.

We observed staff referred to people using their chosen names and these preferences were recorded in care plans. Each person had a named nurse and a keyworker, a member of staff who was responsible for ensuring that person's care plan was up to date and meeting their needs. We saw staff talking to people about their life histories and hobbies, showing that staff knew the people they cared for well and understood what was important to them. One person said, "It's friendly and relaxed. The staff add nice little touches to our care. There is very little to criticise."

Care plans were person-centred, with information about people's needs, preferences, life histories, strengths and what they needed more help with. Some people's care plans were in different formats, such as large print or with symbols, to help them access the information. There was evidence that people had been involved in creating their own care plans and records showed people were involved in reviewing and updating their care plans. Where they were able to do so, people had filled in part of their care plan themselves with information such as what time they liked to get up, what they preferred for breakfast and what they enjoyed talking about. Where people were less able to express themselves verbally, there was information about how to involve them in making choices on a day to day basis, such as by showing them two things to choose between.

Staff told us they made adjustments when required to enable people to understand information and express their views, such as writing things down, and asking doctors and other professionals to do the same, when giving information to a person who was deaf. They told us it was sometimes difficult to support people living with dementia to express their views, but they asked people how they felt about things and offered them simple choices such as two outings to choose between.

Requires Improvement

Is the service caring?

We looked at care records and saw care was usually delivered in accordance with what people had chosen. We asked staff about one person who had been supported to have a bath despite their care plan stating they always preferred showers and never took baths. Staff told us that although they used care plans as a guide, they still asked people each time what they preferred and if they chose something different from usual, they would respect the person's wishes. One person's care plan stated they would like staff to make sure their pencils were always sharp to enable them to participate in a hobby. During our visit we observed staff sharpening pencils for the person and checking they had the activity equipment they needed.

We saw evidence staff received training in promoting people's dignity. The service was working with a university to use their research in promoting dignity for people living with dementia. One member of staff told us experts from the university visited weekly and carried out role plays with staff to help them understand what it was like to receive care and support. The manager told us the service had found this work very helpful in enabling them to support people with dementia to express their views. Staff told us the project supported them to address equality and diversity issues to ensure people received equal treatment according to their diverse needs. We saw evidence that cultural celebrations took place, where people could sample music and food from other cultures. Assessments showed people had been asked about their religious and cultural needs before care was planned.

We observed that people in the home looked well-kempt with clean clothes and brushed hair. The service had carried out a dignity audit shortly before our visit and this looked at things like people's appearance, odour management and use of privacy screens when care was being carried out.

People told us that staff put 'do not disturb' signs on their doors when they were receiving support with personal care so their privacy was respected. In one part of the home, people had keys and knockers on their bedroom doors to help promote their privacy and independence.

Good

Is the service responsive?

Our findings

People's needs were assessed before they began using the service and care was planned in response to their needs. Assessments included general health, medicines, hearing and vision, dietary needs, communication, sleep, continence and mental health. We looked at care plans and saw each person had a number of ongoing monthly assessments to check whether their needs were changing. These included dependency, falls risk, malnutrition risk and pressure sore risk assessments and areas specific to each person, such as monitoring of their health conditions. One relative told us, "[My relative] has been here a long time and her needs have changed over time. The Manager or senior staff have always gone through the care plan with me. [My relative] can't speak on her needs but she's there, and so I do it and the plan is regularly updated. I'm very satisfied with the way I've been involved."

We saw staff offered people varying levels of support according to their needs. For example, when assisting people to move into the dining room for lunch, staff offered some people mobility aids and equipment and encouraged them to use these. For other people, staff offered verbal encouragement and accompanied them if they wished. Staff we spoke with told us they made sure they knew each person's needs and which people required extra support to keep them safe. We noticed that staff encouraged people to do as much for themselves as possible, so as to promote their independence.

Care plans took into account people's communication needs and we saw staff communicating with people according to these. For some people they used simple words with gestures to aid understanding and with others they engaged in more complex conversations.

There was evidence that the service obtained people's consent before carrying out care and treatment. People whose care plans we reviewed had signed consent forms agreeing to the planned care.

The service had links with other services to promote people's community involvement and engagement in meaningful activities. For example, the home had participated in a local art project and people had produced artworks which were exhibited locally. We saw that the home was decorated with examples of people's artwork and staff spoke with pride about people's artistic achievements.

People told us they were supported to visit the shops and nearby market and told us about a trip to Brighton planned for later that week. However, we noted that in one part of the home the activities board was out of date and people did not know what was scheduled to happen. Furthermore, two people told us they did not have anything to do during the day. One person said, "The staff don't say anything: they pass the door and they don't say 'Hello.' I don't do [anything]." This suggests that although activities were available, they may not have been accessible or appropriate for everybody who used the service.

People were enabled to maintain relationships with family and friends. One person said, "My family moved me to be nearer to them and I see them quite often. They take me out when they can." Other people told us staff supported them to contact friends and family.

Staff told us they used information in care plans to meet people's cultural and religious needs but that they also discussed these needs with people where possible. They told us a priest came to the home to do communion and that there were visits from local church volunteers. One person who used the service said, "It's a mixed bag – there are people from different places with different religions here." We saw examples in care plans of how staff supported people to practise their religions.

The home had an 'open door' policy for people to express their concerns. People and their relatives said they could tell staff about things that they didn't like or concerns that they had and staff would try and deal with them. A visitor told us, "I know that if [my relative] is having a bad day I can always go and talk with the manager or senior staff and they will listen. If I need support I know they would give it." However, people in one part of the home told us they did not know whom to speak to about their concerns. The manager told us they would address this in a residents' meeting.

The service had a complaints log showing complaints and concerns that had been recorded, how the service had responded to people with concerns and what action was taken. Managers monitored the complaints log and, if trends were noted or concerns were serious, they put in

Good

Is the service responsive?

place action plans to ensure the service learnt from people's experiences or complaints. For example, when an increase in complaints from relatives regarding a lack of respect was noted, dignity champions were instructed to share learning from dignity and respect training and this became part of staff supervision agendas.

Good

Is the service well-led?

Our findings

Staff told us the manager had daily meetings with team leaders from each part of the home, including those on night shifts, so that they could discuss any concerns. There were daily informal handover meetings for all staff to ensure they were given information they needed to meet people's needs. One member of staff said their team leader knew their job well and was good at listening. During our visit, the manager came into a communal area to speak with people who used the service. We observed that the manager knew everybody's names and people knew who the manager was. A visitor told us, "The manager is excellent. She comes round frequently and talks with each resident. Staff always come in smiling. It's as though they really enjoy their work."

Staff told us the home manager was supportive and encouraged an open culture. This meant that staff felt they were able to speak about any concerns they had. They told us that if there were problems, managers would help them find solutions as a team. They also said ideas and suggestions were welcomed and they were encouraged to try new ways of working. For example, some staff told us when they attended external training they often brought back good practice ideas from staff at other homes to share with their own teams. We saw evidence in staff meeting records that team leaders celebrated the achievements of staff with a staff member of the month award and encouraged the team to show their appreciation of one another's work.

The home carried out annual surveys for people and their relatives to express their opinions about the home and their experiences. We saw the results from the latest survey in November 2013 and people's feedback about the home was positive. Staff told us they supported people who were unable to complete surveys to express their opinions in other ways, such as by chatting with them, taking their histories into account and speaking to family. Although people we spoke with felt they were able to make suggestions and raise concerns, we did not see evidence of people who used the service being formally involved in the development of the service. Surveys were generic and did not ask people's opinions on specific decisions about the service, although some people had the opportunity to attend residents' meetings. However, we did see evidence that people were involved in day-to-day decision-making, such as menu and activity planning.

The registered manager had been in post for two years at the time of our visit. They told us the service had not been achieving well when they came into post and had been failing to meet essential standards. The manager told us how they had worked with other organisations to identify and implement best practice and improve the service so that it achieved compliance with the standards and had remained compliant since then.

There were quarterly quality visits carried out by senior managers. Staff knew who the senior managers were and understood their roles and responsibilities. The provider monitored deaths, complaints, injuries and pressure sores on a monthly basis to ensure any trends were quickly identified. These were then added to the service's risk register with action plans.

We saw evidence the provider monitored the frequency, severity and type of accidents and incidents through monthly reports from the service. The home had a service-level risk register and there was evidence that risks to people's safety, dignity and quality of life were identified, discussed and managed with action plans. These were reviewed at least monthly.

We saw evidence of a monthly falls analysis carried out in each of the four units in the home. The manager told us this had led to a strategy being put in place for one person after the analysis identified they were falling more frequently than expected. This showed that the service was learning from accidents and incidents and was using what they learned to keep people safe and provide a higher quality service. Staff felt the service was "good at learning from mistakes." We saw an example of an incident report where a person had fallen. Actions arising from this included updating the person's care plan to reflect potential warning signs that they may be at increased risk of falling.

The service had a number of audits, some of which had been put into place to monitor progress where problems had been identified. For example, after managers noticed paperwork was going missing from files, they introduced a care file audit which they told us had been helpful in addressing the problem. There were also safety audits in

Good

Is the service well-led?

areas such as medicines and infection control completed within the last six months, and an organisational risk assessment to ensure the provider was aware of risks to the quality of the service overall.

The manager told us the service engaged with commissioning bodies and medical professionals by meeting on a regular basis to discuss the home and best practice. This included best practice in working with people who were prone to pressure sores or experienced incontinence.