The Poplars (Thornaby) Limited

The Poplars Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 2 August 2016 and was unannounced. This meant the registered provider and staff did not know we would be visiting. A second day of inspection took place on 3 August 2016 and was announced.

The service was last inspected in August 2015. At that inspection we found the service did not carry out effective recruitment checks on new staff, did not safely manage medicines and did not effectively manage staff training. These were breaches of our regulations. We did not take enforcement action but required the service to submit a plan telling us how they would be compliant with the regulations. When we returned for this inspection we found the issues identified had been addressed.

Poplars Care Home is located in Thornaby and provides accommodation for up to 43 people who require nursing and personal care. Accommodation is provided over two floors and includes communal lounge and dining areas. Nursing care is provided on the ground floor and residential care on the first floor. There are garden areas surrounding the building which are secure and accessible to people who use the service. A car park is located at the front of the home. At the time of our inspection 38 people were using the service.

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.

People and their relatives said people were safe at the service. Medicines were managed safely. People were supported at their own pace to access their medicines when they wanted them.

Recruitment checks were carried out to minimise the risk of unsuitable staff being employed. Staffing levels were regularly reviewed to ensure enough staff were employed to support people safely. People and their relatives said there were enough staff to support people safely.

Risks to people were assessed and plans put in place to minimise the chances of them occurring. Risks to people arising from the premises and equipment were also assessed and reviewed. Accidents and incidents were investigated and recorded to see if any lessons could be learned to prevent repetition. Plans were in place to support people in emergency situations. There was a business contingency plan in place, to advise staff on how a continuity of care could be provided during events that disrupted the service.

Staff had a good understanding of safeguarding issues and procedures were in place to minimise the risk of abuse occurring.

Staff received mandatory training in a number of areas, including fire safety, food safety, infection control, moving and handling, safeguarding and health and safety. Staff spoke positively about the training they

received and felt supported by regular supervisions and appraisals.

The service was working within the principles of the Mental Capacity Act 2005. Staff had a working knowledge of the Mental Capacity Act and could describe how they applied its principles when delivering care.

People were supported to maintain a healthy diet and were given choice over what they wanted to eat and drink. People were supported to access external professionals to maintain and improve their health.

People told us they were treated with dignity and respect and we saw examples of this during the inspection. People spoke positively about the support they received, describing it as kind and caring. Relatives we spoke with said staff were caring and kind. Procedures were in place to arrange advocates and end of life care should they be needed.

Care delivered was based on people's assessed needs and preferences. Care plans were reviewed every month to ensure they reflected people's current support needs. People and their relatives told us they were involved in planning their care.

People had access to a range of activities, and we saw these taking place during our inspection. Procedures were in place to investigate and respond to complaints.

Staff spoke positively about the culture and values of the service and said the registered manager was supportive and included them, people and their relatives in the running of the service.

Meetings to discuss the running of the service and obtain feedback were held with staff, people using the service and their relatives on a monthly basis. The registered manager and registered provider carried out a number of quality assurance checks to monitor and improve standards at the service. Remedial action was taken when issues were identified.

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.

Risk to people using the service were assessed and remedial action taken to minimise them.

People's medicines were safely managed.

Recruitment systems were in place to minimise the risks of unsuitable staff being employed.

Staff had an understanding of safeguarding issues and the action they would take to ensure people were safe.

Is the service effective?

Good

The service was effective.

Staff received the training they needed to support people effectively and were supported through supervisions and appraisals.

The service was worked within the principles of the Mental Capacity Act 2005 and supported people to make decisions.

People were supported to maintain a healthy diet.

People were supported to access external professionals to maintain and promote their health.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect by staff who knew them well.

Staff took the time to deliver support in a kind a caring way and to create a homely atmosphere.

Procedures were in place to arrange advocates and end of life care should they be needed.

Is the service responsive?

Good

The service was responsive.

Care was planned and delivered in a person-centred and responsive way.

People were supported to access activities and these were regularly reviewed.

The complaints procedure was clear and applied when issues arose.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively about the cultures and values promoted by the registered manager.

Quality assurance checks monitored and improved standards at the service.

Feedback was sought from people and their relatives at regular meetings.

The Poplars Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 and 3 August 2016 and the first day was unannounced. This meant the registered provider and staff did not know we would be visiting. The service was last inspected in August 2015 and at that time was found to be in breach of three of our regulations.

The inspection team consisted of one adult social care inspector and two experts-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.

We reviewed information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The registered 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 contacted the commissioners of the relevant local authorities and the local authority safeguarding team to gain their views of the service provided by the service.

During the inspection we spoke with 19 people who used the service, five relatives and one external professional who was visiting.

We looked at three care plans, medicine administration records (MARs), handover sheets and other documents involving the day to day running of the service. We spoke with eight members of staff, including the registered manager, deputy manager, activities co-ordinator, nursing and care staff and kitchen and

housekeeping staff. We also spoke with a visiting external professional. We looked at four staff files, which included recruitment records.

Good

Is the service safe?

Our findings

We asked people if they felt safe at the service. One person said, "Oh yes. Oh definitely, yes." Another person told us, "Yes. They (staff) never leave me." We asked a relative if the service kept people safe. They responded, "Yes, definitely."

At our inspection in August 2015 we found the service did not carry out effective recruitment checks on new staff and did not safely manage medicines. We required the service to submit a plan telling us how they would be compliant with our regulations. During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in 2015.

Medicines were managed safely. Medicines were delivered on a monthly basis, and when new stock was received this was checked against the medicines people already had. Any stocks carried forward from one month to the next were recorded. This helped to ensure people always had access to sufficient stocks of their medicines.

Each person had a medicine administration record (MAR). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. Each person's MAR contained their photograph and information such as any known allergies, their named nurse and key worker. This helped staff ensure they were administering medicines to the correct person. We reviewed six people's MARs, and saw they were up-to-date and accurately recorded when people had taken their medicines. Where people used 'as and when required' (PRN) medicines guidance was in place for staff on when they might be needed. Topical MARs were used to accurately record the use of topical medicines. These included details of when and where the medicines were applied and the date and time this was done.

Medicines were safely and securely stored. When not in use medicine trolleys were secured to walls in a locked treatment room. Regular temperature checks were taken of the treatment room and medicines fridge to ensure medicines were stored at the appropriate temperature. We did note that temperatures in the treatment room had recorded as high 28℃ in July 2016. A nurse we spoke with said an air conditioning unit had been ordered as a result, and was saw this was delivered during the first day of the inspection. Some people at the service were prescribed controlled drugs. Controlled drugs are medicines that are liable to misuse. These medicines were securely stored and their use appropriately recorded.

We observed a medicine round and saw that people were supported at their own pace to access their medicines when they wanted them. People were told what the medicines were for and asked if they wanted to take them. Staff recorded that medicines were taken immediately after they were used and before they went on to administer other medicines. This helped to minimise the changes of medicine recording errors. People we spoke with said they always received their medicines on time. Staff who administered medicines where assessed annually by the registered manager to make sure they were competent to administer medicines. A nurse we spoke with said the local pharmacy had recently attended to train staff on their systems. Monthly audits of medicine documentation were carried out by the registered manager and

nursing staff.

Recruitment checks were carried out to minimise the risk of unsuitable staff being employed. Applicants for jobs were required to complete an application form setting out their employment history. We reviewed the recruitment records of four members of staff, including two recruited since our last inspection, and saw these application forms were in place. The registered manager said, "I would check (employment gaps) at interview by going through the form with them." At interview applicants were asked care based questions relevant to the position they were applying for, such as, 'What do you think makes a good care assistant?' Two references were sought (including from a previous employer where possible), proof of address and identify obtained and a Disclosure and Barring Service check carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. A member of staff we spoke with said, "They did DBS, references and I was interviewed."

A check was made with the Nursing and Midwifery Council (NMC) on any applicants for nursing positions. The NMC is the professional regulatory body for nurses and maintains a register of nurses and midwives allowed to practise in the UK, including any restrictions that have been placed on the individual's practice. The registered manager also carried out further monthly checks on the NMC registration of nursing staff, and we saw these were up to date.

Staffing levels were regularly reviewed to ensure enough staff were employed to support people safely. The registered manager said a new dependency assessment tool had been introduced since our inspection in 2015. This was completed on monthly basis and helped the registered manager to see how much staff support each person needed. The registered manager said, "It's much better. If I needed to (increase staffing) I would put the hours out for existing staff first, we also have bank staff so I would use them. It is the same for covering sickness and holidays. We don't use agency staff."

On the ground floor day staffing levels (during the week and at weekends) were one nurse and two care assistants. On the first floor day staffing levels (during the week and at weekends) were one senior carer and two care assistants. Night staffing levels (during the week and at weekends) across both floors were one nurse and either a senior carer and two care assistants or three care assistants. Care staff worked across both floors, but there was always a nurse on the ground floor and a senior carer on the first floor. Rotas confirmed these staffing levels.

People and their relatives said there were enough staff to support people safely. One person said, "Yes. (Staffing) is fine here, yes." Another person told us about a fall they had recently, and said five members of staff were there to help very quickly. Another person said, "When I ring the buzzer the [staff] come." We asked another person if they had to wait long for help. They replied, "No, no." A relative we spoke with said staff attended quickly whenever the person rang their buzzer. Staff said staffing levels were sufficient to support people safely. One member of staff said, "There are enough staff. More are being hired as occupancy levels go up." Another told us, "I think there are enough staff. If someone leaves [the registered manager] is straight onto it." A third member of staff said, "Most of the time there are enough staff. If someone phones in sick it is not always possible to cover but we all work as a team."

Risks to people were assessed and plans put in place to minimise the chances of them occurring. When people started using the service they were assessed for risk in a number of areas, including eating and drinking, mobility, skin care, medicines, pain and continence. Recognised tools such as the Malnutrition Universal Screening Tool (MUST), Waterlow and the Abbey pain scale were used to assess risk. MUST is a

screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. Waterlow gives an estimated risk for the development of a pressure sore. Where a risk was identified a care plan was put in place setting out how it could be reduced. For example, one person's mobility risk assessment identified that they were at high risk of falls so various pieces of assistive equipment were arranged for them.

The Abbey Pain Scale is for measurement of pain in people with dementia who cannot verbalise. Risk assessments were reviewed on monthly basis to ensure they reflected people's current risk levels.

Risks to people arising from the premises and equipment were also assessed and reviewed. Maintenance staff carried out monthly checks of window restrictors, beds, water temperatures, fire doors and firefighting equipment. The registered manager reviewed these to see if any remedial action was needed. A fire risk assessment had been carried out by an external company in May 2016. This identified some improvements that needed making, and the registered manager said these had been completed. The registered manager said, "As soon as we got the report in we were straight on to head office (to arrange work)." Required maintenance certificates were in place in areas including legionella testing, gas safety, equipment electrical safety and firefighting equipment.

Accidents and incidents were investigated and recorded to see if any lessons could be learned to prevent repetition. Once an accident or incident form was completed it was reviewed by the registered manager. The registered manager said, "Every month I keep a log of accidents and incidents, and any falls team referrals are recorded. We have a falls champion. They are just getting their head around it but they do teaching with the care assistants." In July 2016 eight accidents and incidents were recorded, most involving people developing urinary tract infections and becoming confused. This had led to GP visits and an increase in people's fluid intake. This showed procedures were in place to learn from accidents and incidents.

Plans were in place to support people in emergency situations. Each person using the service had a personal emergency evacuation plan (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. A summary of people's support needs was listed in an emergency grab bag located next to the front door, though this contained limited information. For example, the summary did not contain details of any equipment the person might need, how many staff were needed to help them or any life critical medicines they used. We asked the registered manager about this and they said the PEEPs would be reviewed immediately to ensure they contained enough information. There was a business contingency plan in place, to advise staff on how a continuity of care could be provided during events that disrupted the service.

Staff had a good understanding of safeguarding issues and procedures were in place to minimise the risk of abuse occurring. Staff had access to a safeguarding policy that provided guidance on the types of abuse that can occur in care settings and how they should respond if they had any concerns. The contact details for the local safeguarding authority were clearly displayed in the reception area of the service which meant they were accessible to people and their relatives. Where issues had been raised we saw evidence that they had been investigated. Staff were able to describe the types of abuse they looked out for and told us they would not hesitate to report them. One member of staff said, "If there is an issue it goes straight to safeguarding." Another member of staff told us, "I would raise if to [the registered manager] or the line manager on duty. I'd go to head office if I wasn't happy. Their contact details are on the wall outside. If I still wasn't happy or thought [the registered manager] was involved I would go straight to safeguarding." There was a whistleblowing policy in place and staff said they would be confident to whistle blow with any concerns they had. Whistleblowing is when a person tells someone they have concerns about the service they work for.

One member of staff told us, "There is a whistleblowing policy and I would be happy to do it."

Throughout the day we saw housekeeping staff cleaning communal areas and people's rooms. As they moved around the building all staff looked out for and moved any tripping hazards they observed. Personal protective equipment (PPE) such as gloves and aprons were readily available for staff. This was used appropriately to assist with infection control.

Good

Is the service effective?

Our findings

At our inspection in August 2015 we found the service did not effectively manage staff training. These were breaches of our regulations. We did not take enforcement action but required the service to submit a plan telling us how they would be compliant with the regulations. When we returned for this inspection we found the issues identified had been addressed.

Staff received mandatory training in a number of areas, including fire safety, food safety, infection control, moving and handling, safeguarding and health and safety. Mandatory training is training the registered provider thinks is necessary to support people safely. Specialist training was provided in areas including behaviours that challenge, wound care and tissue viability. The registered provider had appointed an external training company to manage and deliver the service's training. The training company sent the service a list of training sessions that were available across the course of the year. A senior carer at the service was then responsible for allocating places to staff. If training was needed in an area not included on the training company's list the senior carer said this could be requested. They told us, "For example, in August we were offered palliative care training but I changed that to personal care, care planning and tissue viability. I just phone them to change."

A chart was used to monitor staff completion of training. The registered provider's policy was to refresh mandatory training every year to ensure staff were aware of current best practice. The training chart showed that some staff had not completed mandatory training or were overdue their refresher training. For example, only 11 out of 45 listed staff had completed mandatory food safety training. We asked the senior carer who monitored training about this and they said the training company had only provided one food safety session on the available training list and they were trying to obtain more places. They went on to say all kitchen staff had received food safety training. Where training was overdue on the chart (in safeguarding for example) we were shown evidence that this training was arranged. The registered manager told us – and records confirmed – that the mandatory training required had been expanded in March 2016, which had also led to a delay in staff completing all of the training required. A member of staff was qualified to provide training, and the registered manager said they were being used to assist with staff training.
Staff spoke positively about the training they received. One member of staff said, "With the old provider we got no training. With the new one the training is very engaging. I have just done my fire safety and moving and handling. Because we get tested at the end you really pay attention. We're always able to put it into practice. For example, we improved the sleep (observation) charts after some first aid training to include a breathing column. It helps to give us new ideas and improve." Another member of staff told us, "I enjoy it. It's very practical. We get quite a lot later in the year but I enjoy doing it." Our judgment was that plans were in place to provide the training staff needed and that the service was working hard to achieve this, but that more support could be offered by the training company to ensure relevant training was always available.

Newly recruited staff were required to complete induction training. This included an introduction to the service's policies and procedures, health and safety training and shadowing experience staff. Records in staff files confirmed that this was completed before staff could support people without supervision. Nursing staff were supported to complete their revalidation training. One nurse we spoke with said, "[The registered

manager] is really good at the nursing revalidation. They are taking me through it and also does the nursing competency checks."

Staff were supported by regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff received a minimum of four supervisions a year and an annual appraisal. We also saw records of group supervisions (for example, to discuss data protection) and clinical supervisions for nursing staff. Staff spoke positively about their supervisions and appraisals. One member of staff said, "We get appraisals annually and supervisions continuously. [The registered manager] is always asking us about any concerns. We're always able to have informal chats and [the registered manager] raises things with you." Another member of staff told us, "We review general progress and work and our general development."

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection six people were subject to DoLS authorisations. This was clearly recorded people's care plans, along with details of when the authorisation would expire and any conditions attached. This meant the service was effectively monitoring people's rights under the DoLS process. People who lacked capacity had care plans in place setting out how they could be assisted with their decision making, including details of decisions made in their best interests and multi-disciplinary team meetings to discuss this. This was in keeping with the principles of the Mental Capacity Act.

Staff had a working knowledge of the Mental Capacity Act and could describe how they applied its principles when delivering care. One member of staff said, "If support is needed (with decision making) we raise it to a senior carer and consider involving the Memory Team and [the local mental health] team. We think about how we can make decisions in the best interests of people. If people with capacity make bad decisions we have to accept that." Another member of staff said, "Everyone has the right to make decisions. People can have fluctuating capacity so we wouldn't always go down the DoLS route."

People were supported to maintain a healthy diet. When people started using the service their nutritional needs were assessed and a care plan put in place to support them. These included details of any specialist dietary requirements such soft foods or Percutaneous Endoscopic Gastrostomy (PEG) as well as their dietary preferences. PEG is a system used where people having difficulty swallowing foods and fluids. An overview of people's support needs and preferences was displayed in the kitchen to help ensure people received the food they wanted. People were regularly weighed and their food and fluid monitored to help monitor their nutritional health. Care plans also contained evidence of the involvement of professionals such as dieticians and the speech and language team (SALT) to support people with their food and nutrition.

Kitchen staff visited people each morning to take them through the daily menu and ask what they would like to eat. An easy read menu was used to help people who had difficulty communicating decide what they would like. The cook told us people could choose to eat food that wasn't listed on the menu and people confirmed this was the case. Most people chose to eat their meals in the dining room, which had a pleasant

and welcoming atmosphere. We saw one person who was receiving support from staff to cut up their meal but were eating independently. They were clearly enjoying their food, and told us that if they did not like the food that day staff would offer something else. Another person told us they were on a healthy eating plan and explained how they were involved in choosing the meals they could have as part of this. We asked a third person what they thought of the food at the service, and they said, "It's pretty good, really." A visiting relative told us the food was "lovely" and reflected the person's preferences. A visiting professional said, "The food always looks nice."

People were supported to access external professionals to maintain and improve their health. Care records we looked at contained evidence of the involvement of professionals such as GPs, district nurses, speech and language therapists (SALT), dieticians and the local mental health team. For example, a dietician had been involved to develop an eating and drinking care plan for a person who used a PEG. One person we spoke with said they felt they could always see a GP if they wanted to. Another person told us about visits made by their dentist and chiropodist. This meant people were supported to access the relevant clinician when they needed to.

Good

Is the service caring?

Our findings

People told us they were treated with dignity and respect. One person told us staff treated them with respect and joked they would happily complain if this changed. Another person told us how staff helped to protect their dignity while helping with showering, including by using towels to cover them. Another person described staff as "brilliant" and said they were very respectful. A relative told us the person they were visiting was treated with dignity and respect.

We saw examples of staff treating people with dignity and respect throughout the inspection. Staff spoke with people politely and asked if they needed any assistance before providing it. When staff needed to discuss people's support amongst themselves they moved to quieter areas of the room or building to ensure their conversations remained private. Staff knocked on people's doors before entering. We did see that most people on the ground floor had their room doors open which meant people could see inside when passing. However, when we discussed this with people they confirmed this was their choice and that they wanted their doors open.

People spoke positively about the support they received, describing it as kind and caring. One person we spoke with joked, "I think they've (staff) kind of adopted me" and said, "It's very nice here." Another person said, "Ah, (staff) are lovely." Another person said they liked to keep busy during the day and staff helped them to do this by giving them little jobs to do around the service. The person enjoyed doing this. Another person said they were happy at the service and liked the staff, calling them "little ducks" whenever they passed by. A fifth person told us staff were "brilliant" and helped people to befriend other people using the service. We observed people and staff enjoying friendly conversations throughout the inspection, often sharing jokes together. Staff asked people about their day and what they had planned, and when relatives came to visit it was obvious that staff knew people and their families well.

Relatives we spoke with said staff were caring and kind. One relative told us staff had organised a private meal for a person and their family at the service. Staff had decorated the room especially for the family, and the relative said the person and their family had enjoyed the occasion. A visiting professional told us the care provided was, "Outstanding" and went on to say "staff are so caring and kind" and "treat people like grandparents." Relatives also told us they were free to visit people whenever they wanted. One person we spoke with confirmed this, telling us, "Oh yes. I get visitors all the time."

Staff told us they enjoyed getting to know people and their families. One member of staff said, "I know what people need and want, and you get to know families and their concerns. We make a real effort to deliver extra care. It is so nice when families are there. You get to know them on a personal level but we always keep things professional." Another member of staff told us, "When people first come in I like to introduce myself to them and get to know them."

Staff told us how they were working on introducing a 'make a wish' programme. This would see people listing three things they would like to do or achieve, and every week staff would concentrate on helping a different person work through their list. A member of staff spoke positively about the programme, saying,

"We want to make it so person-centred." Staff told us they hoped to have this running by the end of the year.

At the time of our inspection one person was using an advocate. Advocates help to ensure that people's views and preferences are heard. The registered manager told us the advocate was involved in any best interest decisions made for the person. Procedures were in place to support people to access advocacy services where needed.

No one was receiving end of life care at the time of our inspection. The registered manager explained how this would be put in place where needed. Care records we looked at contained evidence of discussions of end of life care between people, their relatives, staff and GPs.

Good

Is the service responsive?

Our findings

Care delivered was person centred and based on people's assessed needs and preferences. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. Before people started using the service their care and support needs were assessed. This involved speaking with the person, their relatives and other professionals involved in their care to develop support plans that reflected their needs and choices.

Care plans began with a 'This is me' booklet, setting out the person's life history and preferences. This allowed staff who had not met the person before to learn more about them. Care plans were then developed to meet the person's support needs, in areas including decision making, eating and drinking, mobility and falls, personal care, skin care, medicines, sleep and emotional and social well-being. Care plans included details of the support the person needed in each area and guidance to staff on how they wanted this delivered. For example, one person's skin care support plan recorded they were at risk of developing pressure sores and described the positional changes they required to avoid this. We saw from their daily notes that these positional changes were taking place. Another person's mobility care plan said they were anxious when being assisted with the hoist so liked to be constantly reassured when this was taking place.

Where people had a medical condition that caused them pain, a pain care plan was implemented. This helped help staff identify when the person was in pain and how to respond. For example, one person's pain care plan described how staff could use non-verbal indicators to see when they were in pain and set out the medicines they used to help with this. Care plans were reviewed every month to ensure they reflected people's current support needs.

Daily notes were used to record what people had done that day, including their nutritional intake, activities they had participated in and medical appointments. This helped staff coming onto shift ensure they were aware of people's current support needs.

People and their relatives told us they were involved in planning their care. They described how they attended meetings to discuss their plans. For example, one person told us how some support equipment they used had been recently reviewed and that they attended and contributed to all of their care planning meetings. A relative told us they were always invited to a person's care planning meetings, and when they did were encouraged to contribute. This helped ensure care plans were responsive to people's needs and preferences.

People had access to a range of activities. An activities planner was located in the reception area. During the week of our inspection listed activities included a games afternoon, exercise classes, bingo and a visiting singer. We also saw some items borrowed from a local library that had recently been used in a reminiscence session. Most people at the service attended to watch the singer and appeared to enjoy the session. One person told us, "They do put activities on." Another person said, "An entertainer comes in three times a week." People at the service had access to a garden, and a number of them told us they enjoyed using it. A relative told us the person they were visiting was encouraged to take part in the organised activities.

Some people told us they did not want to take part in the activities on offer. The service had an activities co-ordinator. The activity coordinator told us some people did not enjoy group based activities, so they tried to spend individual time with them. This involved helping them with craft activities and to access the local library. The activities co-ordinator said, "I do want everyone to feel equal and want everyone to feel involved."

Procedures were in place to investigate and respond to complaints. The service had a complaints policy, and this was publically displayed in the reception area. The policy explained how complaints would be investigated, though we noted there was no timeframe given for doing so. One complaint had been made since our last inspection in August 2015, and records confirmed this had been investigated and the outcome sent to the parties involved. People and their relatives told us they would be confident to complain if they had any issues and knew how to do so.

Good

Is the service well-led?

Our findings

Staff spoke positively about the culture and values of the service. One member of staff told us, "It's about putting people first. Everything we do puts them at the heart of the service." Another said, "I think we value person-centred care. We tend to all people's needs. People are treated with dignity and respect and staff are very welcoming." A third member of staff told us, "It's just like home. We try to make people feel at home."

Staff said the registered manager was supportive and included them, people and their relatives in the running of the service. One member of staff said, "[The registered manager] is very approachable and supportive. [The registered manager] will do anything for you and give you help if you need it. She is one of the best managers I have seen. We all get on with her." Another member of staff told us, "[The registered manager] is absolutely brilliant. Really good at dealing with difficult situations. She works magic with the staff and is really good at managing staff morale. She gives you responsibility to help you develop, and always tries to improve."

Meetings to discuss the running of the service and obtain feedback were held with staff, people using the service and their relatives on a monthly basis. The dates of future meetings were publically displayed in communal areas. Records of previous meetings confirmed meetings were used to pass on information and to deal with any issues those attending had. For example, a nursing staff meeting in July 2016 had been used to discuss medicine administration. A May 2016 meeting for people using the service and their relatives was used to discuss issues including laundry services and shopping trips. Minutes from meetings were displayed in the reception area so those who could not attend could see what had been discussed. A relative we spoke with said they had not been able to attend a meeting so when they next visited the registered manager had taken time to take them through the minutes of the meeting.

The registered manager and registered provider carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations.

The registered manager carried out monthly audits of areas including housekeeping, meals and nutrition, dignity, the environment and care plans. Where issues were identified a plan was created to show the remedial action needed and when it could be completed. For example, a health and safety audit in June 2016 identified that wheelchairs were being stored near an emergency exit. This led to a more suitable storage area being located for them.

The registered provider carried out a 'monthly monitoring visit.' This involved a review of areas such as training levels, medicines management and the environment. Any remedial actions needed were sent to the registered manager, who said checks were made at the next visit to ensure they had been completed.

We looked at how the service worked with other agencies, such as the local authority, commissioners and safeguarding. The service had recently had a quality monitoring visit by the local Clinical Commissioning

Group (CCG). The CCG shared their report with us, which showed actions were in progress to improve areas identified during their visit. The local authority told us they had no particular concerns about the service and said a positive feature was that many staff – including the registered manager – had worked there for a number of years.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.