Astoria Healthcare Limited

Vicarage Farm Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 29 April 2016 and 3 May 2016 and was unannounced. The service was last inspected on 27 and 28 July 2015 when we found five breaches of the Health and Social Care Act 2008 and associated regulations. At this comprehensive inspection we found the provider had taken action to address the breaches we had identified.

Vicarage Farm Nursing Home is a residential and nursing home registered for up to 59 older people. Some of the people are living with the experience of dementia and some people have health needs which require nursing care. At the time of our inspection there were 57 people living at the home. The home is managed and run by Astoria Healthcare Limited, a private organisation. The organisation does not have any other services.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had taken action to meet the concerns identified at the inspection of 27 and 28 July 2015 and had put in place measures to keep the environment clean and prevent the spread of infections.

Improvements had been made to the training of staff, and we saw that staff were appropriately trained, supervised and appraised to carry out their roles and responsibilities.

Improvements had been made with regards to the way staff treated people who used the service. We saw that staff treated people with kindness and dignity and took into account their human rights and diverse needs.

The provider had taken steps to improve the delivery of activities for people and provided activities which reflected people's individual needs and preferences.

There were appropriate procedures in place for the safeguarding of vulnerable people and these were being followed.

The provider had processes in place for the recording and investigation of incidents and accidents. The risks to people's safety were identified and managed appropriately.

There were enough staff to keep people safe and meet their needs.

The environment had been modified to support orientation and help positive stimulation for people living

with dementia.

The provider was aware of their responsibilities and had acted in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People's nutritional and healthcare needs had been assessed and were met.

Assessments were carried out before support began to ensure the service could provide appropriate care. Care plans were developed from the assessments and reviewed regularly.

There was a complaints procedure in place and people and their relatives knew how to make a complaint. They felt confident that their concerns would be addressed. Relatives were sent questionnaires to gain their feedback on the quality of the care provided.

The provider had a number of systems in place to monitor the quality of the service and put action plans in place where concerns were identified.

People, relatives and professionals we spoke with thought the home was well-led and the staff and management team were approachable and worked well as a team. The staff told us they felt supported by the registered manager and there was a culture of openness and transparency within the service.

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.

Medicines were securely stored and staff followed the procedure for recording and safe administration of medicines.

There were appropriate procedures in place for the safeguarding of vulnerable people. People felt safe when staff were providing support. Staff had received training and demonstrated good knowledge of safeguarding adults.

The provider had processes in place for the recording and investigation of incidents and accidents. The risks to people's safety were identified and managed appropriately.

There were enough staff on duty to meet people's needs in a timely manner.

Is the service effective?

Good

The service was effective.

The provider was aware of their responsibilities and had acted in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People's nutritional and healthcare needs had been assessed and were met.

People were cared for by staff who were suitably trained, supervised and appraised.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a friendly and caring way. People said they were well cared for and had good and caring relationships with all the staff. Relatives and professionals felt that people using the service were well cared for.

Care plans contained people's likes and dislikes and identified the activities they enjoyed, people who were important to them, their cultural and religious needs, and needs relating to their identity. People were supported by caring staff who respected their dignity, human rights and diverse needs.

People were able to make choices and told us the staff respected these.

Is the service responsive?

Good

The service was responsive.

Pre-admission assessments were carried out to ensure the service could provide appropriate care. Care plans were developed from the assessments and reviewed regularly.

People and their relatives were sent questionnaires to ask their views in relation to the quality of the care provided. The registered manager analysed these to ensure that action was taken where concerns were raised.

Activities were planned and took place at the home. The activities coordinator and all the staff engaged with people to deliver these.

Is the service well-led?

Good

The service was well-led.

The provider had a number of systems in place to monitor the quality of the service and put action plans in place where concerns were identified.

People, relatives and professionals we spoke with thought the home was well-led and that the staff and management team were approachable and worked well as a team.

The staff told us they felt supported by the registered manager and there was a culture of openness and transparency within the service.

Vicarage Farm Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 29 April 2016 and 3 May 2016 and was unannounced.

The inspection was carried out by two inspectors including a pharmacist inspector, a specialist advisor and an expert by experience. The specialist advisor on this inspection was a qualified nurse with a background in mental health. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had personal experience of caring for someone living with dementia

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 information we held about the service including notifications of significant events, safeguarding alerts and the findings of previous inspections.

During the inspection we spoke with seven people who used the service, four relatives, the registered manager, the provider and staff on duty including three nurses, five health care assistants, the activity coordinator, and a domestic staff member.

We carried out a Short Observational Framework Inspection (SOFI) because some people were not able to contribute their views. SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at the environment and observed how people were being cared for. We looked at records, including the care records for 14 people, recruitment records for four members of staff, staff supervision and training records, and other records relating to the management of the service.

Following our visit, we spoke with two healthcare professionals and a social care professional involved in the care of people using the service to gather their views about the service.

Good

Is the service safe?

Our findings

At our inspection of 27 and 28 July 2015, we identified that people were at risk of the spread of infection and there was a malodour throughout the home. The provider created an action plan to tell us what they planned to do to improve the environment.

At the inspection of 3 May 2016, we found that the provider had made the necessary improvements in this area. The environment was clean and tidy, and free of malodour, except in one of the lounges where a slight malodour was detected. We made staff aware of this and were assured that there was a reason for this and that the area would be cleaned without delay. We saw that cleaning staff carried out cleaning tasks throughout the day. The provider had purchased new carpets and furniture. One relative told us that the home was always clean and fresh when they visited. A healthcare professional confirmed this and said, "I visit often and it never smells. It is kept very clean."

People told us they felt safe living at the home. One person said, "Yes I do feel safe here", and another told us, "Yes it seems alright." One healthcare professional told us, "I have no concerns for people's safety, I know the staff, they are very good and keep people safe."

Arrangements were in place for the management of people's medicines. We checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in a locked medicines trolley (within a locked room). This assured us that medicines were available at the point of need and stored securely.

Current fridge temperatures were taken each day (including minimum and maximum temperatures). During the inspection (and observing past records), the fridge temperature was found to be in the appropriate range of 2-8°C. This assured us that medicines requiring refrigeration were stored at appropriate temperatures.

People received their medicines as prescribed, including controlled drugs. We looked at 10 MAR charts and found no gaps in the recording of medicines administered, which provided a level of assurance that clients were receiving their medicines safely, consistently and as prescribed. Running balances were kept for medicines that were not dispensed in the monitored dosage system. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed, for example, one or two paracetamol tablets, we saw a record of the actual number of dose units administered to the person. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this, in line with national guidance.

Medicines to be disposed of were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs (CD) were appropriately stored in accordance with legal requirements, with daily audits of quantities done by staff. However, we found that all the CD registers were outside of a locked cabinet. We informed the provider about this and by the end of the inspection all CD registers were safely stored inside a locked cabinet.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviours were not controlled by excessive or inappropriate use of medicines. For example, we saw nine PRN medicines for pain-relief/laxatives recorded on the MAR. We did not see any PRN protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit. However, we found that these were recorded in peoples' care plans instead. This also included information such as risk assessments with certain medicines that had a sedating effect.

Medicines were administered by nurses who had been trained in medicines administration. We found that these yearly training records were not up to date for three members of nursing staff who administered medicines. When raised with the provider, they informed us that they were aware of this and had incorporated it in their training plans. We observed a medicines round and found that staff had a caring attitude towards the administration of medicines for people. Also, we saw that staff wore a protective tabard to ensure that they were not disturbed during the medicines round.

The provider followed current and relevant professional guidance about the management and review of medicines. We saw evidence of several recent audits carried out by the supplying pharmacy and the provider, including safe storage of medicines, room and fridge temperatures and stock quantities on a daily basis. When asked, the provider stated that no medicines incidents/ near misses had been reported recently. However, they demonstrated the correct process verbally of what to do should an incident/near miss arise in the future, including who to contact. This was in-line with the provider's policy.

The provider confirmed they were happy with the arrangement with the supplying community pharmacy and GP, and felt that they received good support with regards to the training of nursing staff of high risk medicines (such as warfarin) and medicines reviews. This was evidenced by checking the record of several medicines reviews that had been carried out within the last six months.

The manager raised alerts of incidents of potential abuse to the local authority's safeguarding team as necessary. They also notified the Care Quality Commission (CQC) as required of allegations of abuse. The manager worked with the local authority's safeguarding team to carry out the necessary investigations and management plans were developed and implemented in response to any concerns identified to support people's safety and wellbeing. A social care professional we spoke with and the records we viewed, confirmed this.

Where there were risks to people's safety and wellbeing, these had been assessed. Person-specific risk assessments and plans were available and based on individual risks that had been identified either at the point of initial assessment or during a review. They included risks of falling, risks associated with people's physical and mental health and nutritional risks. Records of these were detailed and clear and included strategies for reducing risks and keeping people safe. They were reviewed and updated monthly. This included a risk assessment for a person for whom bedrails were being used, to ensure their use was appropriate to keep them safe.

Accidents and incidents were clearly recorded and included details such as time and place, action taken, outcome and steps taken to prevent re-occurrence. This included where a person had a fall and was observed to have a swollen limb. We saw evidence that staff had called the emergency services, informed the GP and next of kin and sent notifications to the Health and Safety Executive (HSE) and CQC. The provider carried out monthly audits of all accidents and incidents. This showed that the provider took appropriate steps to minimise the risk of re-occurrence.

Staff had completed training in safeguarding adults and records confirmed this. They were able to give some definitions of abuse/neglect. They told us they would report any concerns to their manager, or would refer to the information and phone numbers available in the duty office. We saw information and posters on notice boards referring to whistleblowing and safeguarding and numbers to contact for complaints including CQC and the local authority.

The provider had a health and safety policy in place. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. A general risk assessment was in place which included medicines administration, infection control and manual handling. Equipment was regularly serviced to ensure it was safe, and we saw evidence of recent checks. This included fire safety equipment such as fire extinguishers and moving and handling equipment such as hoists. There were regular health and safety meetings to discuss any identified issues, and records confirmed this.

The service had taken steps to protect people in the event of a fire, and we saw that a risk assessment was in place. People's records contained Personal Emergency Evacuation Plans (PEEPS) which took into account people's abilities and needs, how many staff were needed to support them and any specialist equipment they needed.

There were enough staff on duty on the day of our inspection to meet people's needs. The manager told us they did not require the use of agency staff, as they had a large pool of bank staff who were available to cover shifts in the event of staff absence. Where people's assessed needs indicated they required additional support and observation, this had been incorporated into the staffing levels at the home. One person's care plan stated that they had to have one-to-one support but this was not put in place on the day of our inspection. The nurse in charge explained that one member of staff had phoned in sick at short notice which made it difficult to allocate a member of staff to the person. However, we saw that they ensured that there was always a member of staff positioned at the nurses' station opposite the person's bedroom to keep a constant check on the person's wellbeing throughout the morning. We viewed the staff rota for four weeks and saw that all shifts were adequately covered.

Recruitment practices ensured staff were suitable to support people. Checks were carried out before staff started working for the service to ensure they had the relevant previous experience and qualifications. These included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and fitness to work and ensuring a Disclosure and Barring Service (DBS) check was completed.

Good

Is the service effective?

Our findings

At our inspection of 27 and 28 July 2015, we identified that staff had not received training in some areas and some staff did not understand the training they had undertaken.

At the inspection of 3 May 2016, we found that the provider had put in place a comprehensive program of training courses delivered by a recognised external training provider, and that all staff had received training in subjects that the provider had identified as mandatory. This included, safeguarding vulnerable adults, dementia awareness, health and safety and training about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff also received training courses specific to the needs of people who used the service. These included, end of life care, pressure care, care planning and bed rail safety. The manager used a training matrix to record and monitor when staff were due and had attended training. Two of the senior staff had completed a "train the trainer" qualification in infection control and moving and handling. This meant that when staff needed support or additional training, this could be delivered without delay. Training records showed that staff's competencies were routinely assessed after a training session to ensure that they understood what they had been taught. New staff were introduced to the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. This meant that people were cared for by staff who were suitably trained to meet their needs.

At our inspection of 27 and 28 July 2015, we identified that the environment was not designed to support or orientate people who were living with the experience of dementia.

At this inspection, we found that the provider had taken steps to improve the environment and meet the needs of people living with the experience of dementia. People's bedroom doors were brightly painted and displayed people's names. There were signs and pictures to help people find their way to their bedrooms, bathrooms or other communal areas. Corridors on different floors were painted in contrasting colours to help people orientate themselves. There were notice boards in different areas of the home displaying photographs of parties and events that had taken place at the home. There were areas displaying tactile cues such as objects, different kinds of material, dressing up items such as hats and scarves, dolls and pictures from the past for people to pick up and look at. The garden was well maintained and attractive. There were tables, chairs and benches around and a 'bus stop'. We were told by a relative that people liked "waiting for the bus." These provided areas of interest, and enhanced the positive stimulation of people living with the experience of dementia.

During the inspection, we saw that people were consulted and consent to their care and treatment was obtained verbally. Care plans were signed by people or their relatives, and there was evidence that they were involved in regular reviews.

Care records we checked contained 'Do Not Attempt Resuscitation' (DNAR) forms. These are decisions that are made in relation to whether people who are very ill and unwell would benefit from being resuscitated if they stopped breathing. These were authorised by the GP with evidence of consultation with the next of kin

where the person who used the service lacked capacity. People's capacity had been assessed. This meant that people were being appropriately supported when decisions about their care were made.

The Mental Capacity Act (MCA) 2005 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. We found that the provider understood the principles of the MCA and had followed its requirements. The manager had identified people for whom restrictions had to be put in place and had taken appropriate action to make sure these were in people's best interest and were authorised by the local authority as the Supervisory Body. This included a person who required the use of bedrails to prevent them falling out of bed, and the use of keypads to prevent vulnerable people going outside by themselves.

All staff employed at the service had received training in MCA and DoLS. Staff we spoke with demonstrated a limited understanding of the MCA but had a good understanding of DoLS. They were able to provide examples of where they had assessed someone's capacity to make a decision and how decisions could be made in people's best interest if they lacked capacity. We saw information and posters in various areas of the home about the MCA.

During the inspection we spoke with members of staff and looked at staff files to assess how they were supported within their roles. Staff told us and we saw evidence that they received supervision from their line manager every two months. The manager told us that this provided an opportunity to address any issues and to feedback on good practice and areas requiring improvement. Staff also received a yearly appraisal. This enabled staff and their line manager to reflect on their performance and to identify any training needs or career aspirations.

Care files contained a section dedicated to eating and drinking which recorded nutritional status and dietary needs such as the need for fortified or pureed food, swallowing difficulties and assistance required to eat and drink. Food and fluids were monitored for some people at risk of malnutrition and samples seen were well completed and up to date. Malnutrition Universal Screening Tool (MUST) scores were recorded and updated monthly to show people's weight. We saw that people's weight was monitored and recorded monthly. We checked the records for all the people using the service and saw that most people's weight was stable. However where weight loss had been identified, staff had taken appropriate action. This included putting a nutritional plan in place and a referral to the dietician or Speech and Language Therapy (SALT). We checked the care plans for two people recorded to have a nutritional plan in place and saw evidence that staff had followed the care plan and people had gained weight the following month.

People told us the food was good at the home. One person said, "Yes it is good for old people as it is very soft" and "We get rice, mash and chips. It is good." One relative said, "My [family member] does not always eat well. He did not eat his dinner today but when he does not eat, the staff offer him sandwiches, which he likes." People had a choice of food at each meal. There were menus displayed, although these were quite

small and were not pictorial. This meant that people may have had difficulties identifying what was written on the menus. However we saw that people were asked what they wanted to eat at the point of service. We viewed all menus for the week and saw that they changed daily and were rotated across the month. The food served was hot, nutritious and looked appealing. All meals were cooked using fresh ingredients and were served in bright and cheerful dining rooms on each floor. People had adequate amounts to drink. Tea and coffee was served mid-morning and mid-afternoon and jugs of juice and water were available in lounges throughout the day. People were also served hot or cold drinks on request. This meant that the service recognised the importance of food, nutrition, hydration and a healthy diet for people's wellbeing generally, and as part of their daily life.

The service was responsive to people's health needs. A healthcare professional told us that the service was very good at calling them whenever a person required their services. They said, "I have been coming here for years and I know that they are very good and care about people. They call me whenever somebody needs treatment." One relative told us, "They keep me informed of any problems or changes in my [family member]'s condition. They get the doctor whenever she is unwell. I feel relaxed and confident that she is well cared for. Peace of mind." Records showed that people's health needs were monitored and any concerns were recorded and followed up. This included a person whose health had deteriorated and were being nursed in bed most of the time. There was evidence that they had been referred to the relevant healthcare professional, and appropriate treatment had been offered which included appropriate pressure relieving equipment to prevent skin deterioration. One relative told us, "My [family member] has been here three years and has never had a sore. They really look after people here." Care plans contained individual health action plans. These detailed people's health needs and included information about their medical conditions, mental health, medicines, dietary requirements and general information. This showed that the service was meeting people's health needs effectively.

Good

Is the service caring?

Our findings

At our inspection of 27 and 28 July 2015, we identified that some staff did not always treat people with respect and dignity. The provider told us they would take the necessary action to make improvements.

At this inspection we found that improvements had been made. The provider told us they had provided staff with additional training in dementia awareness and reminded staff daily of the need to treat people with dignity at all times. There was a "Dignity board" in the home which displayed information and instructions for staff about how to improve people's lives and their experience of living at the service. This included, "How to improve dignity at meal times", "hygiene and personal care" and "little things that can make a difference, such as knocking on the door, smiling at me, listening to me and sharing a joke."

People and relatives told us, and we saw they were treated with kindness, compassion and dignity. One person told us, "They are good here, very kind." One relative said, "They are marvellous here. Very kind. My [family member] is always clean and cared for. I can relax as I have peace of mind. I have recommended this place to people." A healthcare professional confirmed this and said, "Whenever I have visited I have witnessed how good and kind the staff are to people. It's a good place."

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. There was a table in the entrance hall displaying a compliments book which contained thank you cards and letters from friends and relatives. Some comments we saw included, "Thank you for all your wonderful and attentive care of our [family member]" and "We are grateful to you all for the care given." There was a "treasured memories" book containing photographs of events celebrated at the home.

Staff displayed a gentle and patient approach to caring throughout the day when caring for people in the home. We observed that staff communicated with people clearly and appropriately, making eye contact, offering choices and explaining what they were doing when assisting people. They were attentive when people needed assistance and responded promptly to their needs. When assisting a person to the toilet, staff explained what they were doing and provided guidance and reassurance throughout the process.

We observed lunchtime and saw that staff attended to people's needs in a calm and unrushed manner. They supported people with kindness and patience. Some relatives were visiting and were supporting their family members with their meal. They told us staff offered them lunch, and were always friendly and welcoming. Staff served meals wearing aprons and offered people a choice at the point of serving. We saw that at the end of the meal, staff asked permission to remove empty plates and asked, "Have you finished?", "Can I take your apron off?" and "Thank you."

Staff demonstrated a very good level of engagement with people on an interpersonal as well as practical level. They were cheerful and good natured and took time to speak with people, interacting and chatting with them throughout the day, not only when they were performing physical care tasks. One person commented on the smell of fresh coffee coming into the lounge. A staff member immediately validated their

remark and said, "Would you like a coffee?" to which the person replied they would love one. The staff member immediately left the room and came back with a trolley of tea and coffee for everyone. There was music playing throughout the morning, and we saw people clearly enjoying the songs. One person said, "Oh I love this song" and started singing along to it, which prompted other people to sing and staff joined in. One person was enjoying a card game with a member of staff and we saw that both of them were positively engaged with this activity.

Staff encouraged people to be as independent as they could be and mobilise by themselves as far as possible while taking care to supervise their safety. We saw one staff member gently encouraging a person to transfer from their armchair to a wheelchair with minimal assistance while remaining close at hand in case help was required. They offered encouragement and praise throughout.

Staff were seen to knock on closed doors before entering and said they always respected privacy and dignity by ensuring that people's choices were respected and closing doors when delivering personal care. We saw that bedroom doors were kept open when people were too unwell to get up. Staff told us that this was people's choice as they liked to see what was happening and see staff and visitors coming and going. We saw staff popping in to have a chat with people. This meant that staff were able to keep a watchful eye and prevent people from the feeling of isolation.

People were well presented, in clean clothing and with clean hair and nails. There was a hairdressing salon and a hairdresser visited regularly to attend to people's hair.

Staff were clearly aware of people's needs, routines and behaviour and were able to explain how they supported different people. We saw evidence of kind and empathetic care. We saw some people and staff who spoke the same language engaged in animated conversations. This facilitated communication for people for whom English was not their first language.

There was evidence of information on lifestyle and background in care files we reviewed. We saw a document called "my life story" which included information about the person's background, important people in their life, likes and dislikes, and relevant and significant life events.

People's religious and cultural needs were respected, and care plans included details of this. Church representatives and volunteers visited the home to help people pray and celebrate their religion. Different cultural diets were catered for. One person told us they were Christian and staff took them to church.

People's end of life wishes were recorded in their care plan. We saw evidence that people were supported to remain at the home until the end of their lives if they had expressed this wish. One care plan stated, "To ensure a quality pain-free end of life experience with dignity."

Good

Is the service responsive?

Our findings

At our inspection of 27 and 28 July 2015, we identified that the care of people using the service did not always meet their needs and reflect their preferences. The provider wrote to us telling us they would make the necessary improvements.

At this inspection, we found that the provider had taken appropriate steps and improvements had been made. The provider had recently appointed a second activities coordinator, and they were undergoing recruitment checks at the time of our inspection. There was a record of activities for each person using the service. This included all activities undertaken each month. The activities coordinator had put in place a document named, "Getting to know me". This included background information about people's hobbies and interests and what they liked to do whilst living at the home. Staff told us that this enabled them to support people with activities of their choice. The profile for one person stated that they liked listening to music and getting involved in events and games. Records showed that these activities were offered and that they took part.

Some staff were observed to engage people in activities although not all activities were meaningful or well received by some people. For example, we saw a member of staff attempting to engage a person with a ball game. The person was not interested but the staff member still bounced the ball at them encouraging them by saying, "come on, let's play ball." This clearly annoyed the person who proceeded to get up and tried to leave the unit. A senior member of staff diffused the situation by asking the person if they wanted to go out for a walk, which they did. They said they would speak with staff to ensure they respected the person's wishes in future.

There was an activities board displaying the date, staff on duty, and which activities were planned for the day. On the day of our inspection, activities included reading stories, quizzes and games. We saw that these activities were undertaken in various areas of the home.

Relatives we spoke with were enthusiastic about the activities organised at the home. One relative told us, "There is always something going on here, a bit of singing and dancing" and "It's a happy place with a happy atmosphere, always." However one person who used the service told us there was little to do for more able people. They said, "I used to play chess with a member of staff but they have left now. There's a lot of activities but mainly for old people." The manager told us they intended to continue to develop person-specific activities for people living at the home and were hopeful that the appointment of the second activities coordinator would help meet the needs of individual people.

People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and we saw evidence that people had been involved in discussions about their care, support and any risks that were involved in managing the person's needs. People and their relatives told us they had been involved in the initial assessment. The manager told us that people were referred from the local authority and they had obtained relevant information from them. This included background information for most people which helped understand each person and their individual needs. One social

care professional told us that the service was always responsive to people's needs and they were called regularly to attend to people's healthcare needs when staff identified any concerns.

Care plans were comprehensive and contained sufficient information to know what the care needs were for each person and how to meet them. Each person's care plan was based on their needs, abilities, likes, dislikes and preferences. We saw in one care plan specific instructions for staff to communicate with a person who's condition caused them to display challenging behaviour. These included, "Allow [person] time to process information and respond according to their pace" and "Staff to speak in slow, clear manner and establish eye contact." We observed throughout the day that individual staff member's style of interaction with people changed based on who they were speaking with. This indicated that staff knew people well and were responsive to their individual needs rather than having a 'one size fits all' approach. Relatives of people who did not have capacity told us they had been consulted about their family member's care plans and had agreed to these. They said they were well informed by the staff about the care their relatives received.

The service had a complaints procedure in place and this was available to people who used the service and relatives. One person told us, "I have nothing to complain about." A relative told us they would know who to complain to if they had a concern, but added, "I don't have any concerns, I can relax knowing my [family member] is well cared for." A record was kept of all the complaints received. Each record included the date, nature of the complaint, action taken and outcome. Where complaints had been received, we saw that they had been investigated and the complainants responded to in accordance with the complaints procedure.

People and their relatives were encouraged and supported to feedback about the service through regular meetings and quality questionnaires. These questionnaires included questions relating to how they felt about the care and support they received and whether their needs were being met. It also included questions about the quality of the food, the environment and their social needs. We saw that the results showed an overall satisfaction. Some comments included, "Always friendly", "Lovely calm and relaxed place", "Excellent! Well run and lovely staff", "100% happy with the care" and "I feel the staff do an excellent job. Keep up the good work." Questionnaires were analysed by the registered manager and actions were taken where concerns were raised. There was a board in the entrance hall dedicated to relatives where relevant information was displayed, and friends and relatives were encouraged to contribute their ideas or concerns using a suggestion box.

Good

Is the service well-led?

Our findings

At the inspection of 27 and 28 July 2015 we found that the provider's audits did not always identify, monitor or improve the quality of the service to ensure that the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were being met. The provider wrote to us with an action plan telling us about the improvements they were making at the service.

At the inspection of 3 May 2016 we found that improvements had been made. The provider created an improvement plan which they regularly reviewed and updated.

People and relatives we spoke with were complimentary about the staff and the manager. They said they were approachable and provided a culture of openness. One person told us, "I see the manager around the place. If I had a problem, I would speak with the clinical lead." Another person said, "For older people, this place is very good, not so much for younger people." One relative told us, "The management is excellent!" and "The manager has an open door policy and runs a tight ship." Another relative told us, "I would live here myself. It is always full because they are so good." A healthcare professional informed us that, "The manager is very good and so are the staff."

The registered manager was an experienced nurse who had worked at the service for four years. She had knowledge of the service, each person's needs and the areas of improvements needed. The provider made regular visits to the service and worked closely with the registered manager. They undertook monthly inspections of the service. These included checks of the building, the environment, issues regarding people who used the service and staff and documentation. The registered manager told us that they felt well supported by the provider and communication between them was good.

Staff commented that there was an open and positive culture at the home. They felt supported by senior staff and management and were confident that they could raise concerns or queries at any time. They were complimentary about the registered manager whom they felt was 'hands on', visible and approachable.

The registered manager had put in place a number of different types of audits to review the quality of the care provided. These included medicines audits, environmental checks, health and safety checks and care records. Audits were evaluated and where necessary, action plans were put in place to make improvements in the service. Records were kept of safeguarding concerns, accidents and incidents. We viewed a range of audits which indicated they were thorough and regular.

Staff told us they had regular meetings and records confirmed this. The items discussed included safeguarding, communication/interactions, mealtimes and any other issues identified. Outcomes of complaints, accidents and incidents were discussed so that staff could improve their practice and implement any lessons learnt from the outcome of investigations. Staff meeting minutes confirmed this. There were also regular health and safety meetings, senior staff meetings, and meetings for people who used the service and their relatives. Some of the subjects discussed included staffing, food, activities and outings. This meant people, relatives and staff were able to express their views and have them included in

future plans for the home.

Service user guides were issued to all people living at the service. This included information about the service and the organisation, its aims, objectives and values. We saw that the objectives and values of the organisation included "Treat all people who live and work at the home and all people who visit with respect at all times." The service worked closely with healthcare and social care professionals who provided support and advice so staff could support people safely at the service. Records showed that professionals visited people at the home and had established good working relationships with staff.