Snaith Hall Limited

Snaith Hall Nursing and Residential 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 was carried out on the 22 August and 4 September 2017 and was unannounced.

Snaith Hall Nursing and Residential Home provides accommodation and residential care for up to 47 people. The service supports older people including those with a physical disability and those who may be living with dementia. In May 2016 the provider deregistered two of its three regulated activities and stopped providing nursing care. At the time of this inspection there were 44 people living at the home and receiving a service.

The home has two units, each spread across two floors; The Garden Wing and The Hall and is located near the centre of the town of Snaith, close to shops and amenities in the East Riding of Yorkshire.

Accommodation on both units is provided over two floors and a number of bedrooms have en-suite facilities. People living in the two units have access to outside gardens and seating areas, which are provided in secure settings. There is car parking for staff and visitors to the front and side of the service.

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 registered manager will be referred to as 'manager' throughout the report.

At the last inspection in June 2016 the overall rating for the service was Requires Improvement. This was because they were in breach of four Regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in Regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 18 Staffing and Regulation 17 Good governance. We asked the provider to submit an action plan regarding the breaches identified. During this inspection the actions were met and no further breaches were identified during this inspection.

Systems and processes were in place that helped keep people safe from harm and abuse. Care workers had completed safeguarding training and knew the signs of abuse to look out for and how to raise any concerns.

The provider ensured there were sufficient skilled and qualified care workers to meet people's individual needs and preferences. Recruitment checks were completed that helped the provider to make safer recruiting decisions and minimise the risk of unsuitable people working with vulnerable adults.

Systems and processes ensured that where people had been assessed as requiring assistance with medicines, these were administered safely by trained care workers.

Systems and processes ensured accidents and incidents, complaints and concerns were recorded and

evaluated to identify trends and to reduce the likelihood of re-occurrence.

People's dignity and privacy was protected and people received support from care workers who showed kindness and compassion.

Support plans were person centred and reflected individual's preferences. Information recorded was reviewed and evaluated as a minimum every month and more often where people's needs changed. This meant care workers had access to up to date records that were reflective of people's current needs.

Assessments of risk were carried out to ensure any care and support activities were safe and with minimal restrictions. Assessments were carried out around the home environment to ensure it was safe for everybody. Where any concerns were highlighted action plans were implemented and reviewed for their effectiveness.

The service was working within the principles of the Mental Capacity Act 2005. Care workers understood their responsibilities under the MCA and were actively promoting people's independence. The manager and care workers had an understanding of Deprivation of Liberty Safeguards. They had made appropriate referrals to the relevant authorities to ensure people's rights were protected.

Further work was being completed by the provider to ensure, where a relative had told the service they had a Lasting Power of Attorney that this was validated and the scope of the decision making was recorded

Care workers were supported to update their skills and knowledge. Additional bespoke training was provided to meet any individual needs. Care workers received regular documented supervision to ensure they were supported in their role and development.

People benefited from an enthusiastic activities coordinator who supported people to pursue interests and activities of their choosing. Activities were provided on a group basis or one to one depending on people's preferences and people could participate as much or as little as they choose to.

Any specific dietary needs were recorded in people's care records and this information was shared with the cook and care workers. People had access to a healthy variety of food and drink.

People had access to a range of health professionals who they could visit or who visited the home to provide holistic care and support to maintain people's health and wellbeing.

People, their relatives and other stakeholders were consulted about the service using questionnaires and meetings. Feedback was recorded and evaluated and was used to help shape the home and the service delivery to meet people's individual preferences.

There were robust systems of audit in place to check, monitor and improve the quality of the service. Associated outcomes and actions were recorded with timely outcomes and these were reviewed for their effectiveness.

The provider, manager and staff were committed and enthusiastic about providing a person centred service for people.

Everybody spoke positively about the way the service was managed. Staff understood their levels of responsibility and knew when to escalate any concerns.

The manager had a clear understanding of their role and responsibilities and requirements in regards to their registration with CQC.

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 were protected from avoidable harm and abuse.

People received their medicines safely as prescribed.

Risk assessments provided staff with information to provide safe care and support.

Systems and processes were in place to record and learn from accidents and incidents.

Is the service effective?

Good

The service was effective.

The manager and staff understood their responsibilities in respect of the Mental Capacity Act 2005.

People had a varied diet and had access to other health professionals to maintain their health and wellbeing.

The environment within the home was comfortable, clean and homely.

Is the service caring?

Good

The service was caring.

People's individual care and support needs were understood by care workers, and people were encouraged to be as independent as possible.

People's privacy and dignity was respected by staff who understood when to maintain confidentiality and when to share any concerns.

People's end of life wishes and preferences were recorded where this had been agreed.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in planning their care and support.

Care plans recorded information about people's individual care needs and preferences.

There was a complaints procedure in place and people told us they knew who to speak with if they had a concern or complaint.

People were supported with their interests and activities of choice were available.

Is the service well-led?

Good

The service was well led.

Everybody spoke highly of the registered manager and the provider. Staff understood their roles and responsibilities and when to escalate any concerns.

The registered provider sought the views of people and their relatives through a variety of ways including regular documented meetings and surveys.

Quality assurance systems and processes with associated action plans were used to demonstrate a commitment to continuous improvement.

Snaith Hall Nursing and Residential 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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 August and 4 September 2017 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector and two experts by experience on day one, and one ASC inspector on day two. 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 experts by experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

We looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service.

As part of the inspection process we contacted the local authority for their feedback.

We asked the registered provider to submit a provider information return (PIR) prior to the inspection and this was returned within the given timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection we spoke with the area manager, the manager and the two assistant managers. We spoke with a district nurse and with eight care workers, the activities co-coordinator and a voluntary worker. We spoke with nine people living at the home and receiving a service and five relatives who were visiting people at the home.

We observed interactions between people, relatives and care workers in the communal areas and during mealtimes. We looked at how the provider managed and administered people's medicines and we observed two medication rounds in separate areas of the home.

We spent time in the office looking at records associated with the running and management of the home. We looked at individual care records for four people who lived there and we looked at records on file for five care workers.

Good

Is the service safe?

Our findings

At our previous inspection completed in June 2016, we found risks associated with the health and safety of people using the service were not always thoroughly assessed and effectively managed. This placed people at risk of otherwise avoidable harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. We asked the provider to submit an action plan detailing the actions they intended to take to meet with the breaches we identified. During this inspection we checked and found the actions had been completed and the provider had achieved compliance with regulation 12.

People told us they felt safe. Their comments included, "The doors to the outside are kept locked. Visitors are let in. If I want to go out I ask the staff and they always escort me when I go out." "I can get out into the garden anytime, as long as it's not raining. I love being out it helps me sleep well at night." "Care staff are polite. I have never felt worried about asking for anything."

We observed that care workers ensured people had free access to the communal areas. Other areas such as the stairs to the lower ground floor office, kitchen, medication room and the store rooms were kept locked, to keep the residents safe and avoid any risk of harm to them.

Care workers had received up to date training in safeguarding people from avoidable harm and abuse. They knew how to recognise signs of abuse and how to raise their concerns. Care workers told us, "We have regular training on safeguarding vulnerable adults. If in doubt I ask the manager." "I wouldn't hesitate to raise any concerns and that includes whistleblowing any bad practice." An assistant manager said, "We make sure care workers are not afraid to ask if they need any assistance or if they are not sure. Care workers are trained and supervised so they become confident."

Along with accidents and incidents, we saw processes in place ensured safeguarding concerns were recorded, evaluated and where appropriate actions were implemented to reduce the likelihood of a re-occurrence.

Care plans we looked at included risk assessments for both people's individual needs and for those associated with the environment. For example, care plans included a risk assessment screening tool that had been completed to provide a basis for the support plan used by care workers. This meant care workers had guidance that helped them to provide people with safe care and support when completing activities of care that included, moving and handling, medication and personal care, with minimal restrictions in place to maintain people's independence.

Records were maintained where people had been assessed as at risk from skin tears, pressure sores and at risk from weight loss and falls. These records were evaluated and ensured additional support was provided where needed to help keep people safe.

The provider completed checks that ensured the home and any equipment was safe. Service certificates

were up to date and provided assurances that the lift, premises, and equipment were being maintained in a safe condition. Checks were completed to ensure beds and associated equipment, for example, bed rails were safe for people to use. The manager told us, "This equipment is supplied and serviced by a third party supplier, so we assume it will be safe; we do still carry out our own additional observations." We found one bed had a large gap at the foot of the mattress. We were concerned this posed a safety risk to the person and discussed this with the manager. The manager was pro-active and raised the concerns with the supplier. They carried out additional checks with the Health and Safety Executive to ensure the equipment was safe to use.

There were current maintenance certificates in place for the fire alarm system, fire extinguishers, portable electrical appliances, gas safety and the electrical installation. There was a fire risk assessment in place and certification that checks had been completed to prevent Legionella. Legionella is water borne virus that can cause lung diseases similar to pneumonia.

At our previous inspection, completed in June 2016, we found the provider had had not taken appropriate steps to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. We asked the provider to submit an action plan detailing the actions they intended to take to meet with the breaches we identified. During this inspection we checked and found the actions had been completed and the provider had achieved compliance with regulation 12.

During this inspection we checked the policies and procedures in place for medicines management and we observed people receiving their medicines over the lunch time period. There was a designated care worker who had responsibility for medicines. We observed they wore a red tabard whilst dispensing medication to avoid being disturbed. The care worker checked the Medication Administration Record (MAR), administered the medication and waited until the person had taken the medicine, assisting where necessary before completing the MAR.

Staff involved with medicines had received up to date training. Spot checks ensured care workers were competent in their role. The assistant manager said, "We all have routine checks that ensure we follow best practice and guidance and further training and support is available where required."

There was a system and process in place for the ordering, storage, handling and disposal of medicines and this was in line with best practice. Protocols for administering medicines that were prescribed as, 'as and when required' for people were in place. Records were up to date and audits were completed to maintain safe practice.

People confirmed there were enough care workers on duty. During the day, between 07:30 and 22:00, records confirmed there were six care workers on duty and four care workers at night time. We observed people's call buzzers were being answered promptly throughout the inspection. At lunch those who needed assistance, received help from care workers. There were enough care workers to ensure people received personal care and regular pressure area care to those who were on bed rest so that pressure sores and skin damage could be avoided. People told us, "When I press the call bell staff are quick answering it. If they are busy they come as soon as they can and always apologise for the delay." "I need two staff to attend to me. Staff will come in and explain that they were waiting for the second person. They get to me as soon as they can. I am happy with that." A care worker told us, "We could always do with more staff but we are a good team and are very supportive of each other, it seems to work well."

The provider had completed pre-employment checks that helped to ensure care workers were of suitable

character to work with vulnerable people. This included checks with previous employers, where we saw references had been obtained and recorded, and checks with the Disclosure and Barring Service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands and can help employers make safer recruitment decisions. Care workers had completed application forms, interviews and health checks that ensured they were fit and healthy and understood the expectations of their role.

The provider had contingency plans in place to ensure people's safety was maintained and service continuity was planned for in the event of an emergency situation. Personal Emergency Evacuation Plans (PEEPs) were in place documenting individual evacuation plans for people who would need assistance to leave the home, for example in the event of a fire.

The manager had a policy and procedure in place to manage infection control around the home. The manager completed monthly infection prevention and control audits that included a monitoring form for care workers and cleaners to record and sign where checks had been completed. Any areas of concern were discussed during routine meetings. Training in this area was completed and recorded for all staff as part of their induction programme and spot checks ensured care workers maintained high levels of cleanliness and infection control around the home.

Good

Is the service effective?

Our findings

At our previous inspection, completed in June 2016, we found that although there was a training programme in place and there was a supervision plan for care workers, training and supervision was not always up to date. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. We asked the provider to submit an action plan detailing the actions they intended to take to meet with the breaches we identified. During this inspection we checked and found the actions had been completed and the provider had achieved compliance with regulation 18.

It was clear from our observations and from talking with care workers that they were skilled in their role and understood people's needs. Care workers we spoke with told us they received regular training and that this was managed well by the management team. The manager provided us with a training matrix that detailed areas of training completed by care workers that the provider considered to be mandatory. This included safeguarding, moving and handling, health and safety, infection control, first aid and food hygiene. Other areas of training were recorded where care workers were required to provide care and support to meet people's individual needs for example, dementia care, end of life, and diabetes. People were confident that care workers delivered care that met their needs. Relatives were very complimentary about the care delivered to their family members. On person said, "I have a lot of visitors and some are in the medical field. They have asked me and they have seen how I have been looked after; they have been very happy with the care."

The provider ensured all care workers received an induction to their role, the service provided and the people who lived there. This included an oversight of policies and procedures, housekeeping and an introduction to peoples' records. A care worker told us, "The induction was great; I had good support from existing staff which helped me to find my feet." Another care worker said, "I am completing my induction at the moment; everybody is very friendly and supportive which makes it a very good experience for me. I have regular meetings with the manager who checks to see how I am progressing."

The manager told us new employees completed the care certificate and were encouraged to complete higher level vocational qualifications in health and social care. Records confirmed this. The care certificate is a set of basic standards in providing care and support for care workers to adhere to in their daily role.

The manager said they carried out supervisions with care workers every eight weeks and completed an annual appraisal. Care workers told us they felt supported in their role and confirmed they received regular supervisions and annual appraisals. A care worker told us, "I have had two supervisions but I haven't been here long enough to complete an appraisal. The supervisions are very useful; we can discuss almost anything and they are an opportunity to air any concerns or training requirements; also to ensure we are doing things properly." The manager provided us with a schedule detailing these events which had been completed with care workers.

At our previous inspection, completed in June 2016, we found consent to care and treatment was not always sought in line with relevant legislation and guidance. This was a breach of Regulation 11 of the

Health and Social Care Act 2008 (Regulated Activities) Need for Consent. We asked the provider to submit an action plan detailing the actions they intended to take to meet with the breaches we identified. During this inspection we checked and found the actions had been completed and the provider had achieved compliance with regulation 11.

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 and found the service was working within the principles of the MCA. At the time of our inspection there were thirty one people living at the home who had restrictions in place. The provider had submitted applications to the local authority for further assessment and authorisation of DoLS for those people in line with the MCA. Care workers told us and records confirmed they had received training in the MCA. Care plans included assessments by the provider that recorded when they had assessed people's capacity. Care worker's said, "When people first move in we assume they have full capacity unless it is proven otherwise." "Even if someone has a DoLS in place they might still be able to make smaller day to day decisions like choosing clothes; it's important we encourage people to be independent whenever it's possible; I would ask someone for their opinion or agreement to any care or support."

All the relatives we spoke with told us that where their family member did not have the capacity to make decisions, that they had been approached by the manager and senior staff and had been involved in making decisions as part of the person's best interest meetings. Where best interest meetings were recorded these included consent from representatives appointed with Lasting Power of Attorney (LPOA). A LPOA is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. We saw this information was recorded in their care plan. Care workers were aware of, and followed this information for example, when reviewing care plans and seeking support with any decision making on behalf of people.

The provider had completed checks to validate LPOA and the scope of the authorised decision making. Because of those checks we evidenced that LPOA's were not always valid and did not always include the scope of the appointee's decision making for the person's care and support. The manager told us further work was planned to ensure care plans accurately recorded where a LPOA had been validated and the scope of the appointee to make decisions on behalf of the person.

People's care plans contained information about their medical needs and how care workers were required to support the person to maintain their health. Previous and current health issues were recorded and healthcare professional were contacted where further support was needed. We saw evidence recorded of involvement from other health professionals that included their GP, community nurse, chiropodists and community mental health workers.

People and their relatives told us that the GP visited the home every Friday and they were able to see the GP. However, if they became ill during the week care workers confirmed they did not hesitate to call the GP. One person and two relatives provided us with examples where the GP was called during the week to treat a chest infection and help manage another person who was in pain.

The assistant manager informed us that every year around September and October, the GP visited the home when residents' MAR charts were reviewed. They told us the GP completed a check on any previous diagnosis and administered flu vaccinations to people. This visit helped care workers to confirm the diagnosis of residents and seek any further assistance from other health professionals where this was required.

District nurses visited the home every day delivering nursing care to people. One district nurse we spoke with said, "This home is one of the good ones. Care workers are open to our suggestions and take on-board and act on them. They refer to the logs we keep on residents. We do dressings, daily insulin, enema and anything people need. I am happy with the care I see being delivered."

People were supported with their nutritional and dietary requirements. Information on any specific needs was recorded in people's care plans and the chef confirmed they discussed people's dietary requirements with people and offered a choice of food.

We observed the end of breakfast and the lunchtime period. On the first day of the inspection there were 15 people in the dining room and a further five had their lunch in their rooms as they were cared for in bed. People were invited, and where required supported to the dining room by care workers. We saw care workers encouraged people to mobilise to the dining room.

Everybody was given a choice of meals. The food served looked appetising and had a lovely aroma. People who wanted small portions were given their request. Two care workers sat with people who needed assistance and others served and assisted people in their rooms. One person had a pureed diet. We observed how the pureed meal was served in shapes which looked like meat and veg. This was commended by the relative who was present.

Everybody we spoke with made positive comments about the food. They said, "Marvellous; can't complain." "The food is very good here; plenty to eat." "We can have snacks if we want them. I don't very often; my stomach tells me when I have had enough so I don't need snacks." "We are given choices and we see the cook. They sometimes help with dishing out."

We saw the environment within the home was comfortable, clean and homely. People were able to navigate around the service both unassisted and with their walking aids such as wheelchairs and walking frames. The home had an enclosed garden area and some rooms had direct outdoor access. One person told us, "I like to go out in the garden, do some dead heading of flowers and a bit of weeding; it helps me to have a good night's sleep." Another said, "You will see we have bird food out but we seem to get more squirrels than anything; they're great to watch."

Good

Is the service caring?

Our findings

We observed staff being kind, compassionate and respectful towards people. This was supported by people's feedback, they told us, "When they [care workers] come to see to me, they are very caring and jovial which makes me feel better. Before they leave they always ask me if I have got everything and check I am okay. They never rush off." "If I need to wait a while because they [care workers] are busy, one of them will nip in and tell me that they are only going to be another five minutes; that's because they care. They can't be everywhere at the same time." "I often tell the carers that there are people worse off than me so tell them to come to me when they have finished helping others. Care workers always say we are here for you as well so don't worry about calling us. They have a lot on their plate but they are good."

We observed care workers knocked on people's doors and waited for them to answer and agree before entering their rooms. Care workers routinely engaged people in conversation asking them how they were, if they needed anything and what their plans were for the day. Records included people's preference to a male or female care worker and care workers told us this was respected.

People assured us that care workers had meaningful relationship with them, that they cared about them and understood their needs and helped them settle in the home and have a fulfilled life. There was a clear, good relationship between people and care workers. It was evident people knew the care workers and the care workers knew people well. Care workers told us, "I am so lucky to work here; I don't consider it a job, more a big family." "We make sure each person gets the best possible care; we all have pride in our work and that comes down from the top; when we have difficult days there is support available and reassurance to carry on."

Relatives and people said they were involved in the planning of care and able to influence the delivery of care. A relative said, "They [care workers] know what is going on and if I need an update on anything I just need to ask, communication is very good." Another relative showed us the documentation in a person's room. They discussed the information recorded where turns and food and fluid charts were completed. We noted they were regularly completed by staff and kept up to date. The relative said, "We have access to this information which helps to demonstrate [Name] is being well cared for in line with their needs."

The provider ensured people's personal beliefs were supported. People we spoke with confirmed they could take part in spiritual activities if they so wished. One person said that they loved singing. They told us that on Sundays they went out with a church group and sang songs. Another person told us they received Holy Communion once a week when their vicar was around. One relative said, "Care workers listen to the family suggestions, deliver the best care. We are very impressed with staff commitment."

Where people had chosen to, their end of life care wishes and any advance decisions were documented in their care plans and kept under review. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate. An assistant manager told us this was a sensitive subject to discuss with people and their relatives but that they were pro-active in recording people's wishes. We spoke with a relative about end of life care at the home. The relative was very happy in the way the care had been

organised with regular monitoring of pain management, ensuring the person was comfortable, and with the treatment plan. The relative said, "I suggested to staff not to disturb [Name] if they were asleep in order to carry out some of the care activities such as turns. This was respected since [Name] was in receipt of end of life care, so they were able to get sufficient rest."

Residents told us and our observations confirmed people were able to receive visitors without any restrictions. Visitors said that they were able to visit any time. A relative confirmed, "I'm here seven days a week nine till five but I can visit at any time; and I do."

Good

Is the service responsive?

Our findings

The provider had developed a personalised approach to responding to people's needs. Before people moved into the home their needs were assessed to ensure the service was suitable for them. Following this initial assessment, individual care plans were developed that provided guidance about how each person would like to receive their care and support, including their preferred routines of care and how they communicated their needs.

A care worker said, "Care plans are a good starting point but we get to know people's likes and dislikes by getting to know them; we have time for one to one chat." A snap shot of a person's life had been completed. This provided members of staff with information about their family, hobbies, and interests, where they were born, their working life and any food preferences. We also saw recorded what relatives had said they admired about the individual and what the person said was important to them.

Each person's care plan had a one-page personal profile that included their photograph, details of their next of kin, other health professionals involved in their care and details of any religious beliefs. Information was also recorded that ensured the person's abilities, wishes and preferences were recorded for daily activities. Examples included, washing and dressing, hair care, foot care, sight, tissue viability, falls history and continence. Information recorded the type of support and how much the person could do for themselves. A care worker told us, "Care plans are a good reference point for information and we can easily identify areas where support is required and areas where we can encourage and promote people's independence."

Records showed care plans were evaluated for their effectiveness with monthly reviews evident. This included monthly reviews of risk assessments for preventing falls and reviews of people's cognition that included their behaviour and capacity to make informed decisions about their care and support. Records were amended where people's needs had changed.

Where concerns were evident, we saw the provider had implemented further monitoring and as appropriate the assistance of other health professionals. For example, a person had been diagnosed with Dysphagia. Dysphagia is the medical term for swallowing difficulties. As a result the provider had completed a best interest meeting to review the care and support in place. This had included input from a Speech and Language Therapist (SALT). A nutrition screening pathway had been implemented and along with a Malnutrition Universal Screening Tool (MUST) monitored the person's weight and diet to help maintain the person's health and wellbeing. MUST is a five-step screening tool to identify adults, who are malnourished or at risk of malnutrition.

The manager told us people were offered a choice of personal care options. People we spoke with confirmed this and told us that they were happy having a wash in their rooms and having a shower every other day. Two people told us they were not given the choice of having a bath but insisted that they were happy with the shower. We saw this information was recorded in people's care plans as part of a personal profile of care needed.

The provider had a process in place that meant where people were required to access external services for example, a hospital, information was available that ensured they would continue receive care and support appropriate to their needs. An assistant manager said, "Up to date information is available in people's care plans and in their MAR. This would go with any medication they were taking should they be admitted to hospital."

Residents benefitted from the enthusiasm and creativity of an activities coordinator. It was clear they had a good understanding of people's individual preferences and they showed us how they had compiled an individualised portfolio from discussions with people and their relatives. The activities coordinator said, "I spend time with each resident to find out their particular likes and dislikes, favourite music, games, hobbies, pastimes and arrange activities to suit." We observed how they used this information when organising events. The coordinator said, "We had a competition in the house when some students came in on the national citizen's service scheme. There were three students and three residents on each side and they were cheering and shouting for each other."

People were encouraged to participate and the activities coordinator discussed how they communicated with people to understand their preferences and to ensure people were safe from social isolation. They said, "My greatest satisfaction is when I'm with one person who has difficulty communicating; their eyes light up to a particular line in for example a Vera Lynn song. I know I have helped to rekindle a memory and it's great to see people smiling and enjoying themselves."

People told us there was a Wednesday walk outside but only if the weather was good. One person said, "I enjoy getting out, I lived on a farm and I am used to the fresh air." The activities coordinator said, "If the forecast is bad then we have a 'Tuesday trek' and we include people who use wheelchairs on the rambles." We were introduced to a volunteer leading on activities which were referred to as 'Shirley time'. This was attended by a number of people from the home. We saw people who took part were chatting, laughing and enjoying themselves. These meant residents were offered relevant and meaningful activities to participate in that they enjoyed.

The provider had a policy in place that provided guidance on how people could raise concerns and how the provider would respond to any complaints. An audit was in place that was evaluated quarterly to identify any trends in the types of complaints received. These meant actions could be implemented to mitigate re-occurrence of those concerns.

People and their relatives we spoke with told us they had not had any reason to make any formal complaints. They said that if they wanted anything changing they spoke with the manager or the senior on duty. One relative said "In the early days we had to prompt care workers to do things but as they got used to [person's name] things fell into place." Care workers told us they were mindful of residents' and relatives' expectations. They told us, "If we have not done something right, we get to know and we are always quick to respond without delay. Most concerns can be dealt with as they happen but we would provide assistance to anybody who wanted to make a formal complaint to go through the process."

People and their relatives we spoke with told us they would be very happy to share their views with the manager and care workers if they needed to. There was also a record of compliments and thank you cards from people and relatives expressing gratitude for the care provided by the service.

Good

Is the service well-led?

Our findings

At our previous inspection, completed in June 2016, we found that people were not always protected against the risks of inappropriate or unsafe care and treatment because of ineffective operation of quality assurance systems to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. The registered provider failed to maintain an accurate record of care and treatment in respect of each person using the service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit an action plan detailing the actions they intended to take to meet with the breaches we identified. During this inspection we checked and found the actions had been completed and the provider had achieved compliance with regulation 17.

The provider had completed in depth quality assurance checks to maintain and identify any areas for improvement. Care plans were reviewed and evaluated for their effectiveness in maintaining people's health and wellbeing. Monthly audits had been completed for people's weight, safety, medication, falls, accidents and incidents, skin condition, moving and handling, environments and complaints. Information was collated and had oversight from the manager and the area manager that ensured any actions were implemented in a timely manner and, where trends became evident further evaluation and preventative actions could be implemented. Where people's needs changed we saw actions implemented that included the involvement of other health professionals where appropriate to do so. The quality assurance systems ensured people were supported with their health to live and enjoy their lives without taking unnecessary risks and without undue restrictions in place.

Everybody we spoke with told us they were happy with the management in place and found them to be open, approachable and transparent. Care workers told us, "There has been a massive improvement over the last 12 months; paperwork has improved and is up to date, the medication process has improved, and I feel supported and valued as an employee. I wouldn't hesitate to raise any concerns." "It is like a big family. The manager is great; I can talk to them about anything." "I don't think we need to implement anything new; we just to need to keep maintaining and where we can, improve on what we have got." "They [management] are proactive and address any concerns straight away; after all they are accountable for the service."

The provider ensured information was shared through the home and service with everybody involved. Regular meetings with care workers, managers, domestic staff, kitchen staff and senior care workers were held and provided an opportunity for open dialogue and information sharing. A care worker told us, "We have regular staff meetings; they are useful as we are informed of any planned changes and we can have our say and input into what is going on".

The provider was proactive about making improvements to the service. Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, meetings and one to one session.

Residents and relatives' said that they had been to meetings held by the manager to discuss matters relating

to the home when they had been asked for their opinions. The manager confirmed that they held regular meetings. Minutes of resident meetings were evidenced. These had included discussions about decorating, activities, care planning and relative involvement and discussed comments from a suggestions box that had been implemented.

The provider had completed in depth infection control audits and had worked with the local authority to ensure systems and process in place at the home were fit for the purpose and in line with best practice and regulation.

The provider had completed three surveys over 2016 and 2017 with people and their relatives. The manager told us, "We evaluate the responses and feedback and the information is included in the 'Quality Assurance' report and used to focus on any improvements we may need to implement." The Quality Assurance report included information from people's feedback, information from audits, outcomes from maintenance and inspections and input from external organisations for example, health watch and the food hygiene standards. The area manager said, "The document provides transparency and highlights what is working well and any areas for improvement."

There was a clear staffing structure and staff we spoke with had a clear understanding of their role and when to escalate any concerns. Care workers said the management including the directors were very much involved in the home and that they were approachable and listened to their views. One care worker said, "One of the directors likes to help out with gardening and the other used to be a nurse so they help with any practice issues."

All care workers and ancillary staff we spoke with said they loved the atmosphere and liked working for this provider.