G Hudson & S Dobb

The Meadows Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1 and 7 February 2017. The first day of our inspection visit was unannounced.

The Meadows Care Home provides personal and nursing care for up to 70 people. People are accommodated in two separate buildings. Rose Court has 40 beds for people who need nursing care. Lavender Court has 30 beds for people who need residential care. At the time of our inspection, there were 55 people living there: 24 people in Lavender Court and 31 people in Rose Court. The service provides care for younger and older people, people living with dementia, and people living with physical disabilities.

The service had a registered manager at the time of our inspection visit. 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 were not consistently kept safe from the risk of infection. The overall system to ensure equipment was kept clean was not effective. We discussed this with the registered manager, and immediate action was taken to resolve these concerns.

People experienced varying levels of support to maintain interests and hobbies. The provider employed two activity coordinators, but one had been off work for an extended period of time. This meant there was one staff member responsible for organising and coordinating activities for 55 people across two buildings. Although the provider had taken steps to cover this absence, there had been an impact on people's ability to take part in activities that were meaningful to them.

People's care needs were assessed and recorded and risks identified. Risk assessments and care plans identified steps staff should take to reduce the risk of avoidable harm. Accidents and incidents were monitored and reviewed, and action taken to reduce the risk of harm occurring. There were enough staff to ensure people received their personal and nursing care.

People were happy with staff who provided their personal care, and felt safe living at The Meadows Care Home. People had medicines available when they needed them and were given these in accordance with prescribing instructions. They were cared for by sufficient staff who were suitably skilled, experienced and knowledgeable about people's needs. Staff worked in cooperation with health and social care professionals to ensure that people received appropriate healthcare and treatment in a timely manner. People were supported to have sufficient to eat and drink, and people who needed assistance to eat were provided with support.

The provider took steps to ensure potential staff were suitable to work with people needing care. Staff received supervision and had checks on their knowledge and skills. They also received an induction and training in a range of skills the provider felt necessary to meet the needs of people at the service.

People and their relatives confirmed that staff sought permission before offering personal care. Appropriate arrangements were in place to assess whether people were able to consent to their care. The provider met the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS).

People felt cared for by staff who treated them with kindness, dignity and respect. The support people received was tailored to meet their individual needs. People, their relatives, and staff felt able to raise concerns or suggestions in relation to the quality of care. The provider had a complaints procedure to ensure that issues with quality of care were addressed. The provider also sought people, relatives' and staff views in order to take action to improve the quality of the service.

The service was well-led. The provider had systems to monitor and review all aspects of the service. These were undertaken regularly, areas for improvement were identified and acted on. The provider was looking at innovative methods to improve people's food experience. There was an open and inclusive culture within the service, and staff had clear guidance on the standards of care expected of them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always kept safe from risks associated with the risk of infection. People were kept safe from the risk of potential abuse. People's medicines were managed safely and in accordance with professional guidance.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and experienced to provide their personal care. The provider was working in accordance with the Mental Capacity Act 2005 (MCA). People were supported to access health services when they needed to.

Is the service caring?

Good

The service was caring.

People felt supported by staff who provided care in a dignified and compassionate way. People felt staff listened to them and their views mattered. People were supported to spend private time with their friends and family if they wished.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People experienced varying levels of support to maintain interests and hobbies. Staff were knowledgeable about people's individual care needs and preferences. People and relatives felt able to raise concerns and knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

People and relatives felt the service was managed well. People, relatives and staff felt able to make suggestions to improve the service, and raise concerns if necessary. The provider had

systems to monitor and review all aspects of the service.

The Meadows 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 1 and 7 February 2017. The first day of our inspection visit was unannounced. The inspection visit was carried out by one inspector, two specialist advisors, and two expert-by-experiences. One specialist advisor was an occupational therapist, and the other was a nurse. Expert-by-experiences are people who have personal experience of using or caring for someone who use this type of care service. The second day of our inspection was carried out by one inspector.

Before the inspection, we asked the provider to complete 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. This was returned to us by the service.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, notifications of serious injuries or allegations of abuse. We spoke with the local authority and health commissioning teams, and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

During the inspection we spoke with 20 people who used the service, and seven relatives. We spoke with nine staff and the registered manager. We also spoke with four staff from the provider's senior management team. We looked at a range of records related to how the service was managed. These included 12 people's care records (including their medicine administration records), four staff recruitment and training files, and the provider's quality auditing system.

Not all of the people living at the service were able to fully express their views about their care. We used the

Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People were not consistently kept safe from the risk of infection. The system to ensure equipment was kept clean was not effective. We saw a number of wheelchairs and other equipment that were not clean. Used mattresses, wheelchairs and other equipment were stored alongside new mattresses. We saw slings being stored unsafely. Slings are used with hoists to assist people to transfer safely, for example, from a wheelchair to a chair. We found a number of slings rolled up and stored on the floor of a cupboard or on top of other equipment. This meant they were at risk of cross-contamination. Handrails in toilets and commodes were visibly dirty. Staff told us, and records showed there was a system in place for regularly checking the cleanliness of equipment. The registered manager confirmed there were storage issues with slings and equipment. Immediate action was taken to remove equipment that was no longer needed, and to check and clean all equipment. The provider also reviewed how daily and weekly checks of equipment were carried out, and took steps to improve this.

There were enough staff to provide the personal and nursing care people needed. However, people had mixed views about the support they had to take part in meaningful activities, or to sit and talk with staff. One person commented, "They do look after you – the carers are very nice people. But they're always busy, too busy to chat." People felt staff always responded quickly when they needed support. A person said, "I get help quickly – they come and check on me." We saw staff respond to people's need for care in a timely manner throughout our inspection. Relatives felt there were enough staff to meet people's personal and nursing needs, but several relatives said staff rarely had time to sit with people and talk. Staff felt there were enough of them to ensure people were cared for safely, but felt they did not always have time to sit with someone if this was needed. One staff member said, "I wish we had more time sometimes to sit and talk with people – we do talk with them whilst doing personal care." We saw staff responded to people's needs in a timely manner during our inspection visit. The provider used a dependency tool to help the registered manager establish how many staff were needed for each shift. This was reviewed whenever people's needs changed, which meant the provider could adjust staffing levels to meet people's needs. This showed there were enough staff to meet people's personal care and nursing needs, but staff did not always have time to sit with people and talk with them about topics that were meaningful to them.

People felt safe living at The Meadows Care Home. One person described how staff supported them, "They come and help me get up and get to bed. I feel safe here." Another person said they felt, "Safe and looked after." Relatives also felt their family members were cared for safely. Staff had good knowledge of risks and demonstrated that they understood how to keep people safe from the risk of avoidable harm. Risk assessments were person-centred and detailed the steps people and staff needed to take to ensure people received safe care. For example, people who were at risk of developing pressure ulcers were regularly assessed to ensure they had the correct pressure relieving equipment, and were being supported in ways that reduced the risk of skin breakdown. We also saw people being supported safely to transfer from wheelchairs to seats using hoists. Staff used the equipment correctly, and ensured people understood what was happening before using the equipment. People were reassured by this and transferred safely. People were involved in the risk assessment process where they were able to. Risk assessments (and associated care plans) were reviewed with people regularly and updated to ensure staff knew how to support people

safely. People were protected from the risk of avoidable harm.

People were kept safe from the risk of potential abuse. They felt safe, and were confident to tell staff if they were concerned about anything. Relatives were confident in the staff team's ability to ensure their family members were safe. Relatives were also confident in raising any concerns about people's care. Staff knew how to identify people at risk and were confident to recognise and report concerns about abuse or suspected abuse. They also knew how to contact the local authority or the Care Quality Commission (CQC) with concerns if this was needed. The provider had clear policies on safeguarding people from the risk of abuse, and staff knew how to follow this. Staff received training in safeguarding people from the risk of avoidable harm and this was supported by their training records. Records at the service confirmed where staff skills fell below the standard expected by the provider, steps were taken to address this. This ensured people were kept safe from the risks associated with unsafe care.

Accidents and incidents were reviewed and monitored to identify potential trends and to prevent reoccurrences. We saw documentation to support this, and saw where action had been taken to minimise the risk of future accidents. For example, one person was at risk of falls, and records showed they had fallen 22 times in a three month period. As well as receiving appropriate medical attention in relation to each fall, they had been assessed by the GP and referred for specialist support to reduce the risk of falls.

Staff told us, and records showed the provider undertook pre-employment checks, which helped to ensure prospective staff were suitable to care for people they were supporting. This included obtaining employment and character references, and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. All staff had a probationary period before being employed permanently. This helped reassure people and their relatives that staff were of good character and were fit to carry out their work.

People's medicines were managed safely and in accordance with professional guidance. One person told us they always got medicine at the right time, and staff always talked with them about their medicines. Relatives were confident their family members received medicines as prescribed. People felt staff supported them to manage their medicines safely, and confirmed that staff recorded this. Staff told us, and records showed, they received training and had checks to ensure they managed medicines safely. Staff knew what action to take if they identified a medicines error and there were checks in place to ensure any issues were identified quickly and action taken as a result. The provider had up to date guidance for staff which was accessible for staff who dealt with medicines. We observed that, during medicine administration, nursing staff involved were expected to also take responsibility for answering the telephone. Staff told us, and records showed this was the practice in the home. This meant there was a risk staff involved in administering medicines were distracted. We spoke with the registered manager and management team about this, and they agreed to change this practice to minimise the risk of avoidable medicines errors. All medicines were stored, documented, administered and disposed of in accordance with current guidance and legislation. Staff took time to explain to people what their medicines were for, and checked that people were happy to take their medicines. This meant people received their medicines as prescribed.

The provider ensured risks associated with the service environment were assessed and steps taken to minimise risks. Staff and records confirmed this was the case. People's files contained emergency information and contact details for relatives and other key people in their lives. Each person had a personal emergency evacuation plan (PEEP) which contained detailed information on how to support each person to remain safe in the event of an emergency. Staff knew what to do in the event of an emergency, and the provider had a business contingency plan in place. This meant people would be reassured and supported safely in ways that suited them if there was an emergency.

Good

Is the service effective?

Our findings

People were not always supported to access information about food choices in ways which were meaningful to them. We saw that written menus were not always displayed clearly enough to show people what the meal choices were, and there were no pictures to assist people in choosing their meals. The provider was in the process of introducing a new approach to show people clearly what their meal options were. This was being developed following recent dementia training, but had not yet been introduced. This meant people who had difficulty with written information did not always know what choices were available to them. The provider demonstrated they had plans to improve this area of care, but these were not in place at the time of our inspection.

People said they liked the food and were offered choices. One person said, "I like the food. I can get a drink if I want." Another person said, "Food's okay here." A third person said, "The food here is really good and I look forward to it." One relative commented their family member had put weight on and looked healthy. Another relative said, "They used to get urine infections all the time, but since they've been here they've not had one, and I think that's because they get lots of drinks." People were offered regular drinks and snacks throughout the day. People were provided with adapted cutlery and equipment to enable them to eat and drink independently. For example, several people had cups with handles that enabled them to drink independently, and adapted cutlery was used by people who needed it. Staff knew who needed additional support to eat or had special diets, for example, fortified diets or appropriately textured food and thickened drinks. People who were at risk of not having enough food or drinks were assessed and monitored, and where appropriate, advice was sought from external health professionals. People were supported to have sufficient to eat and drink, but this was not consistently done safely or in a dignified manner.

People were supported by staff who were trained and experienced to provide their personal and nursing care. One person described what their personal and health care needs were, and how staff were trained to support them well. Relatives spoke positively about the quality of care staff provided for their family members. Two relatives described how their family members' health and well-being had improved since moving to The Meadows Care Home.

All staff had a probationary period before being employed permanently. New staff undertook the Care Certificate as part of their induction, and all staff were working towards or had achieved this. The Care Certificate is a set of nationally agreed care standards linked to values and behaviours that unregulated health and social care workers should adhere to. The provider had an induction for new staff which included training, shadowing experienced colleagues, being introduced to the people they would be caring for, and skills checks. The provider had a "buddy" system to ensure new staff were matched with experienced staff to support them. One staff member said, "I worked alongside staff, and this was good. I got to know people's individual needs and what they liked." Staff told us they felt their induction gave them the skills to be able to meet people's needs.

Staff undertook training in a range of areas the provider considered essential, including safeguarding, medicines, nutrition and supporting people with dementia. Staff told us, and records showed that they

received refresher training in areas of care the provider felt necessary to meet the needs of people at the service. Staff also confirmed they could ask for additional training. Nursing staff had access to revalidation with the Nursing and Midwifery Council (NMC). This process ensured nurses maintain their nursing practice up to date. They must undertake a specified number of hours of training in relation to their role, including reflection and feedback from people to ensure they are safe to practise as a nurse.

The provider supported staff to undertake additional specialist training. For example, one of the management staff had training in dementia mapping and supported staff to develop care plans tailored to individual people's dementia needs. Dementia mapping is an established approach to achieving and embedding person-centred care for people with dementia, recognized by the National Institute for Health and Clinical Excellence. It is used by care staff to improve quality of life for people living with dementia and supports staff to take the perspective of the person with dementia in assessing the quality of the care they provide. All staff at The Meadows Care Home had recently taken part in "virtual" dementia training designed to give them deeper understanding of people's experience of dementia. Staff described this as, "Very inspiring," and, "The best training I've ever done – really helped me put myself in other people's shoes, and has changed the way I approach people." Staff demonstrated they were putting this training into practice. For example, one person preferred to move around Rose Court, and responded well to staff who would sing and dance with her. One staff said, "They're not wandering – they're walking about for a reason and I understand that better now." When the person appeared anxious or unsettled, staff interacted with the person in ways they responded positively to. All staff had, or were working towards, achieving nationally recognised qualifications in health and social care. The provider and registered manager had robust recording in place to ensure they monitored what training staff needed, and ensured they attended training the provider deemed essential. This meant people were supported by staff who had the appropriate skills and experience to provide them with the individual support they needed, at the times when they needed.

Staff told us, and evidence showed, daily records were kept of key events relating to people's care. Information about people's care was recorded and staff shared key information with colleagues throughout the day and at shift handover. The provider held meetings for staff to discuss information relating to people's care. This included regular meetings to discuss people's care towards the end of life, domestic staff meetings to ensure the home environment was kept clean, and kitchen staff meetings to ensure people's nutritional needs and preferences were met. Staff also had individual meetings with their supervisor to discuss their work performance, training and development. This was accordance with the provider's policy, and records confirmed supervision meetings took place. This meant that staff knew what action was needed to ensure people received care they needed.

The provider was working in accordance with the Mental Capacity Act 2005 (MCA). The 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 so that they can 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.

People and their relatives confirmed that staff sought permission before offering personal care. One person said, "They ask if I can take my blood – I'm always having that done." They described how they appreciated staff talking with them about what care they needed, and checking they agreed to treatment or care. Staff understood the principles of the MCA, including how to support people to make their own decisions. Staff

understood what the law required them to do if a person lacked the capacity to make a specific decision about their care. Where people had capacity to consent to their personal care, this was documented. Where people lacked capacity to make certain decisions, the provider followed the principles of the MCA to ensure best interest decisions were made lawfully. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to provide restrictive care that amounts to a deprivation of liberty. The provider had assessed people as being at risk of being deprived of their liberty and had made applications to the relevant Supervisory Bodies appropriately for a number of people. The provider was working in accordance with the MCA, and people had their rights upheld in this respect.

People were supported to access health services when they needed to. One person said, "They talk to me about what I need and the doctor will come if I need him." Another person said, "They're very good at getting the doctor out." Relatives said they were happy with the way people were supported to access health services in a timely manner. One relative was pleased their family member, "Looks more healthy and is much happier since coming here." A visiting health professional commented on staff having a proactive attitude to ensuring people received the healthcare they needed, and said staff always followed their advice. They spoke positively about people being supported to maintain a healthy weight, and evidence from relatives and records supported this. Staff told us, and records confirmed, people were supported to access health services when needed. For example, one person was regularly seen by a specialist nurse, and had been supported to see a GP in a timely manner. Another person, who had pressure ulcers was regularly assessed and treated in accordance with nationally recognised good practice for skin care. Records demonstrated how staff recorded any concerns or action needed in relation to people's health. This enabled staff to monitor people's health and ensure they accessed health and social care services when required.

Good

Is the service caring?

Our findings

People felt supported by staff who provided care in a dignified and compassionate way. One person said, "The carers are lovely. I'd recommend it to anyone." Another person said, "They [staff] are very kind and caring, they have a lot of patience." Relatives were positive about staff being kind and caring. One relative commented, "The carers seem to go that extra mile to make sure residents are happy. It was [my family member's] birthday a few days ago, and staff provided a cake and we had a party." Another relative described how well staff knew their family member, and said this meant staff noticed and responded quickly to changes in the person's mood and health. They said, "Staff are genuinely caring. They understand people and what they need," and said this was demonstrated by the way they behaved. We also saw written feedback submitted by relatives and other visitors in the form of cards and emails that spoke positively about the way staff provided care. One relative said, "We cannot thank the staff enough for being so thoughtful and kind."

Throughout our inspection visit, staff supported people in a caring, friendly and respectful way. Staff knew people well, calling them by their preferred names, and were knowledgeable about people's preferences. They ensured people were comfortable and took time to explain what was happening around them in a patient and reassuring manner. Staff spent time with people who appeared anxious or agitated. For example, one person was agitated during a meal, and moved about the home with their food. Staff supported them to do this calmly, and the person responded well to this. This reduced their agitation and they were able to continue to eat their meal.

People and their relatives felt involved in planning and reviewing their care and support. One relative commented positively on how well staff involved them in reviewing their family member's care, and said they were confident people were treated with respect. Staff told us people were supported to express their views and wishes about their daily lives. Care records we looked at had clear evidence of people, relatives or their representatives being involved in reviews. People's care plans recorded preferences about how they were supported. For example, one person's care plan contained information about their past occupations, and information about other people and events that were important to them.

People were supported in a dignified way. We saw one person receiving specialist care. The person wished to remain in the lounge, so staff used a mobile screen to ensure more privacy. Staff understood how to support people in ways that maintained their dignity. For example, when people were supported to move using a hoist, staff ensured people were comfortable and that their clothing covered them appropriately. Staff described other ways of ensuring people's care was done in a dignified way, for example, by ensuring doors and curtains were closed when providing personal care. During our inspection visit we saw staff demonstrate that they provided care in ways that protected people's dignity and privacy. This meant people's dignity was central to staff values, and staff provided care in ways that upheld this.

Staff understood how to keep information about people's care confidential, and knew why and when to share information appropriately. We saw throughout the inspection staff did not discuss people's personal matters in front of others, and where necessary, had conversations about care in private areas of the home.

Care staff had access to the relevant information they needed to support people on a day to day basis. Records relating to people's ongoing care were stored securely. We identified that the archive storage for records was not secure. Staff confirmed the storage should be locked at all times, and there were records demonstrating the storage area was regularly checked to ensure it was secure. The registered manager took steps to resolve the issue immediately. This showed people's confidentiality was respected.

People were supported to spend private time with their friends and family if they wished. Relatives told us they were able to visit whenever people wished, and there were no restrictions on visiting times. This showed people's right to private and family lives were respected.

People and, where appropriate, their relatives were involved in discussions about their wishes regarding care towards the end of their lives. This included where people would like to be at the end of their lives, whether they would like to receive medical treatment if they became unwell, and in what circumstances. People had advance care plans in place which included, where appropriate, clear records of their wishes about resuscitation. Where people were able to make this decision for themselves, this was documented. Where people could not, evidence showed that external medical professionals had followed the Mental Capacity Act 2005, and a best interest decision had been made. Staff involved in end of life care met regularly to discuss people's needs and ensure they were being met appropriately. This included ensuring staff knew people's cultural and religious needs at this time. Staff received additional training to ensure they knew how to support people at the end of life. The provider demonstrated that arrangements for people's end of life care met the five priorities for care, which are nationally recognised best practice. This meant people were supported to express their views about their future care towards the end of their lives, and staff knew how to support people and their relatives in the way they wanted.

Requires Improvement

Is the service responsive?

Our findings

People experienced varying levels of support to maintain interests and hobbies. They told us that they did not do much during the day to occupy their time. One person said, "You can play bingo here, but I don't like it. I suppose I just relax every day." Another person said, "I just watch the world go by," and a third person commented "I do sit here a lot." One staff member said, "I wish we had more time sometimes to sit and talk with people – we do talk with them whilst doing personal care." The provider employed two activity coordinators, but one had been off work for an extended period of time. This meant there was one staff member responsible for organising and coordinating activities for 55 people across two buildings. Although the provider had put extra care staff on shifts to cover this absence, there had been an impact on people's ability to take part in activities that were meaningful to them. For example, a television was on in a lounge all day. People sitting nearby told us they did not want to watch the programmes that were on and confirmed no-one had asked them what they wanted to watch. After lunch, one person sitting directly in front of the television confirmed they did not want to watch it, and this was where they had been sat by staff after lunch. We noted that many people in Lavender Court had recently been unwell, and were recovering. This meant there were not many people there participating in activities during our inspection visit.

We saw some people being supported to take part in individual and group activities. However, people in the communal areas of the home received a varying amount of support from staff to engage in conversations or interests. We observed some, but not all staff took opportunities to engage people in interesting conversations to stimulate them. Activities were mainly focussed on individual and group leisure, hobbies and entertainment. There was information available in both Rose Court and Lavender Court about different group activities and entertainment planned. However, records relating to people's meaningful activity did not consistently contain enough information about how often they were supported to take part. The provider confirmed this was the case, and was speaking with staff about how to improve recording what activities people were offered and what they took part in. Several people in Lavender Court said they would like to be supported to make themselves drinks. There was a kitchen designed for this and similar activities. The provider's website information states, "Our most recent addition includes a domestic kitchen where residents can get involved in baking and cooking for pleasure and occupational therapy." We found no evidence that the kitchen was being used for this purpose. People and staff told us the kitchen was not used in this way. We asked the provider to consider reviewing the use of the kitchen. This meant people were not consistently supported to remain active, and to participate in activities that interested them.

People who used the service felt listened to, and that staff responded to their needs and wishes. Staff were knowledgeable about people's individual care needs and preferences. They also demonstrated they knew about people's life histories and what was important to them. For example, some people were supported to create books with pictures and memories from their past. Staff said, and records showed these were used to promote conversation and reminiscence.

The provider ensured people had their personal care needs reviewed, and relatives were involved with this where people consented. People's care plans contained information about their likes and dislikes, hobbies and friendships, and key information about life events. Where it was not possible to obtain this information

from people directly, staff asked family members to provide information they felt was important about people's lifestyle choices. People's care plans reflected their personal choices and preferences for their daily lives. Some people needed additional support or time to communicate. For example, one person had a communication book which had been developed with them. This enabled them to supplement their limited verbal speech with written words and pictures. We saw staff using the communication book to assist the person to express themselves.

People and relatives told us they had opportunities to provide feedback on the quality of their care. This was done through surveys of people's views, reviews of people's care, by speaking with care staff, and talking with the registered manager. The provider also sent people and their relatives' information on what was happening in the service, any feedback they had received and what actions they planned to take to improve the service. For example, people had given feedback in relation to availability of activities. The provider had employed another activities coordinator as a result. This demonstrated the provider listened to people's views and suggestions to improve the quality of care and took action.

People and their relatives felt any issues or complaints would be handled appropriately by the provider. They felt able to raise concerns and knew how to make a complaint. One relative described how staff had immediately attended to their concern when they raised it. Staff knew how to support people to make a complaint. There was information around the service about how to make a complaint. The provider had a complaints policy and procedure in place, which recorded the nature of the complaint, what action was taken and who had responsibility for this. We saw where action had been taken as a result of complaints. For example, a relative complained their family member was unable to see the television because furniture blocked their view. The provider spoke with the person and relative, and the best solution for the person was to change the position of the television, which was done promptly. The provider also looked at complaints on a regular basis to see whether there were any themes they needed to take action to improve. This meant the provider had a responsive system to resolve concerns and complaints.

Good

Is the service well-led?

Our findings

People and relatives felt the service was managed well. People did not always recall who the registered manager was, but they knew key staff involved in their care, and were positive about the service being well-managed. One relative said, "[My family member] is lots better here. They get a lot of poorly days, but the carers are fantastic with them." Another relative described the service as, "It's marvellous; excellent. One of the best I've been in." Staff spoke positively about their work and the support they received from the provider and from each other.

Staff understood their roles and responsibilities, and demonstrated they were trained and supported to provide care that was in accordance with the provider's statement of purpose. A statement of purpose (SOP) is a legally required document that includes a standard set of information about a provider's service, including the provider's aims, objectives and values in providing the service. During our inspection, staff were open and helpful, and demonstrated knowledge of people's needs.

The provider encouraged staff to develop new or innovative approaches to providing good care for people. For example, the provider's catering manager was in the process of developing new ways to present food appropriate for people on soft diets. They told us this would improve choice for people, and make food look more appetising, and encourage them to improve their diet. The techniques being used to do this were designed to retain the nutritional quality of food and to present food in a visually appealing way. The provider was also investigating the suitability of a new product designed to enable people at high risk of choking to enjoy tasting experiences, and help improve mouth hydration. Staff described the technique as being, "For mouth and flavour stimulation, especially for people receiving end of life care." The provider was seeking advice from external professionals on the suitability of the product for people, and we saw a demonstration with the staff team which was received very positively. Staff spoke about individual people who they felt would benefit from having the taste experience. This showed the provider was looking for new ways to improve the quality of care for people at the service.

People, relatives and staff felt able to make suggestions to improve the service, and raise concerns if necessary. The provider also regularly sought people and relatives' views about the service, responded to comments and complaints, and investigated where care had been below the standards expected. This assured us people, relatives and staff were able to make suggestions and raise concerns about care, and the provider listened and acted on them.

The provider appropriately notified CQC of any significant events as they are legally required to do. They had also notified other relevant agencies of incidents and events when required. The registered manager regularly contacted Care Quality Commission (CQC) to discuss any issues or concerns that might impact on the quality of care. The registered manager also understood their duties and responsibilities with respect to providing personal and nursing care. They had undertaken specialist training in developing and improving the culture of dementia care, and staff spoke positively about the effect this had on their ability to support people. The service had established effective links with local health and social care organisations and worked in partnership with other professionals to ensure people had the care and support they needed.

The provider had policies and procedures which set out what was expected of staff when supporting people. The provider's whistleblowing policy supported staff to question practice and assured protection for individual members of staff should they need to raise concerns regarding the practice of others. Staff confirmed if they had any concerns they would report them and felt confident the registered manager would take appropriate action. This demonstrated an open and inclusive culture within the service, and gave staff clear guidance on the standards of care expected of them.

There were systems in place to monitor and review the quality of the service. The registered manager and provider carried out both routine and unannounced checks of the quality and safety of people's care. Checks included daily, weekly, monthly and quarterly monitoring of people's care and the service environment, how people felt about care and regularly seeking people's views about the service. For example, in January 2017, a medicines error was identified during an audit, and action was taken to ensure the risk of this occurring again was reduced. We identified that the audit system did not support staff to monitor the cleanliness of slings for hoists, or the cleanliness of wheelchairs, and spoke with the registered manager about this. Action was taken on the first day of the inspection visit to remedy this. The provider also investigated where care had been below the standards expected and took steps to improve people's care.

The provider undertook essential monitoring, maintenance and upgrading of the home environment. The system used to ensure maintenance and other essential tasks were done was robust, and enabled key staff to flag up issues, which were dealt with in a timely manner. For example, during our inspection visit, the fire safety systems were checked as part of the provider's ongoing maintenance of the building.