South Yorkshire Care Limited

Cathedral Nursing Home

Inspection report

23 Nettleham Road
Lincoln
Lincolnshire
LN2 1RQ

Tel: 01522526715

Date of inspection visit:
16 January 2017

Date of publication:
30 March 2017

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

We carried out an unannounced comprehensive inspection of this service in March 2016. Breaches of legal requirements were found and we rated the service as 'requires improvement'. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

The inspection took place on 16 January 2017 and was unannounced.

The Cathedral Nursing Home is registered to provide accommodation and nursing and personal care for up to 38 older people or people living with dementia. There were 37 people living at the service on the day of our inspection.

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

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment. Several people living at the service had their freedom lawfully restricted under a DoLS authorisation.

Staff undertook appropriate risk assessments for all aspects of a person's care to keep them safe from harm. Care plans were developed to support people's individual needs. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People received their prescribed medicine safely from staff that were competent to do so. The registered provider ensured that there were always sufficient numbers of staff on duty to keep people safe.

People were supported to have a healthy and nutritious diet and hot and cold drinks and snacks were available throughout the day. People had their healthcare needs identified and were able to access healthcare professionals such as their GP and dentist. Staff knew how to access specialist professional help when needed.

People were at the centre of the caring process and staff acknowledged them as unique individuals. Relatives told us that staff were kind and caring and we saw examples of good care practice. People were always treated with dignity and respect. People were cared for by staff that were supported to undertake training to improve their knowledge and advance their skills to enable them to perform their roles and responsibilities effectively.

People were supported to have an active life and were encouraged to take part in hobbies and interests of their choice. Relatives commented that their loved ones were well looked after.

People where able, were supported to make decisions about their care and treatment and maintain their independence. People and their relatives had access to information about how to make a complaint. Relatives told us that they could approach staff with concerns and knew how to make a formal complaint to the provider.

The registered provider had introduced robust systems to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. People, their relatives and staff found the registered manager approachable.

Overall, we found that the registered manager had led their team to introduce and sustain improvements to the service, such as medicine management, infection control and monitoring the quality of 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.

People had their risk of harm assessed for all aspects of their care. Staff knew how to keep people safe.

Staff were aware of safeguarding issues, knew how to recognise signs of abuse and how to raise concerns.

The service was clean and staff had access to hand washing facilities and protective equipment.

Medicines were ordered, stored, administered and disposed of safely. Staff were assessed as competent to administer medicines.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities effectively.

Staff ensured people received a nutritious and balanced diet.

People were supported to maintain good health and received support from healthcare professionals when the need was identified.

Is the service caring?

Good

The service was caring.

People were supported by kind, caring and compassionate staff that treated them with kindness.

Where able people were involved in decisions about their care.

People were treated with dignity and staff respected their individual choices, needs and preferences.

Is the service responsive?

Good

The service was responsive.

People's care was regularly assessed, planned and reviewed to meet their individual care needs.

People were enabled to take part in a range pastimes and interests.

Is the service well-led?

Good

The service was well-led.

The provider had introduced regular quality checks to help ensure that people received safe and appropriate care and treatment.

Staff felt able to raise concerns with the registered manager. Staff were aware of the whistleblowing policy and procedure.

People and their relatives found the registered manager approachable.

Cathedral 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.'

The inspection took place on 16 January 2017 and was unannounced. The inspection team was made up of one inspector, a specialist advisor for infection control and medicines and an expert by experience.

An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This was because we were following up on previous breaches of the regulations.

We looked at information we held about the provider. This included notifications which are events which happened in the service that the provider is required to tell us about.

During our inspection we spoke with the registered manager, a registered nurse, two members of care staff, the cook, a kitchen assistant, the housekeeper, the activity coordinator and 11 people who lived at the service and four visiting relatives. We also observed staff interacting with people in communal areas, providing care and support. In addition we spoke with two visiting healthcare professionals.

We looked at a range of records related to the running of and the quality of the service. These included five staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for nine people and medicine administration records.

Good

Is the service safe?

Our findings

At our previous inspection in March 2016 we identified that medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

On this inspection we found that medicines were managed safely and the provider was no longer in breach of the regulation.

People received their medicine from staff that had received training in medicines management and had been assessed as competent to administer them. At breakfast time we observed medicines being administered to people and noted that appropriate safety checks were carried out and the administration records were completed. Staff told us that they had completed medicine management training and had their competency checked before they were permitted to administer medicines unsupervised. The registered nurse wore a red tabard to indicate to other staff, people who lived at the service and visitors that they were not to be disturbed during the medicine round. We observed that there were no interruptions.

We looked at medicine administration records (MAR) and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was asleep. We found where a person managed some of their own medicines such as an inhaler, that a plan was in place and this was reviewed every six months. When a person was prescribed medicine through a skin patch, a body map was in place and identified the areas where the patch was to be applied, to minimise the risk of damage to the person's skin. When a person was prescribed as required medicine, such as pain relief, staff had protocols to enable them to administer the medicine safely. We noted that when a person who lacked the capacity to take their medicines that they received their medicine covertly; that is, hidden in their food that this had been discussed and approved by their GP. We saw that the pharmacist had also been involved. However the record of their involvement was not kept with their MAR chart. We brought this to the registered manager's attention who said that they would ensure that in future all medicine documentation was kept with the person's MAR chart.

All medicines were stored accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines and the medicines policy. We learnt that all medicine incidents were reported through a formal route and the registered manager investigated them.

At our previous inspection in March 2016 we identified that the premises and equipment were not clean,

secure and properly maintained. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

On this inspection we found that premises and equipment were clean, secure and properly maintained and the provider was no longer in breach of the regulation.

Several areas of the service had been redecorated and recarpeted since our last inspection. People told us that they had been involved in choosing the decoration. This provided a much improved environment and the service had a homely feel to it. We saw that there were generous supplies of protective equipment, such as aprons and gloves in all areas of the service and that staff used them appropriately. Hand gel dispensers were easily accessible throughout the service and there was guidance in shared toilets and ensuite facilities about safe and effective handwashing practices. Two members of staff had been nominated as the infection control leads for the service and had attended regular infection control forum meetings provided by the local authority.

We spoke with a member of the housekeeping team who told us that they now had daily, weekly and monthly cleaning schedules and that these were signed on completion of a cleaning task. We looked at the cleaning schedules and checklist and saw that all cleaning duties had been signed as completed. The housekeeper also informed us that they had been trained in the safe use and storage of cleaning products. The cleaning products were stored securely in a locked cupboard and housekeeping staff had guidance of the safe use of cleaning products such as detergents and toilet cleaner.

We spoke with the laundry assistant who told us that there had been a lot of improvements since our last inspection. For example, soiled laundry was now stored safely overnight and not left where people could access it and they now had a cleaning schedule for the laundry. We saw evidence of cleaning schedules in other areas of the service, such as two hourly hygiene checks in all toilets.

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. All staff had received training on how to keep people safe and how to recognise signs of abuse. Staff told us that they would report any concerns they had about person's safety to the registered manager or the clinical lead. The registered nurse in charge of the shift told us how they would escalate any identified concerns to the local safeguarding authority.

There were systems in place to support staff when the registered manager was not on duty. Staff had access to an emergency folder that contained contingency plans to be actioned in an emergency situation such as a fire or electrical failure. Staff had access to on-call senior staff out of hours for support and guidance. Furthermore, people had an individual emergency evacuation plan to be used to help them leave the premises safely in an emergency situation, such as a fire.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as their risk of having a fall or developing sore and damaged skin. Care plans were in place to enable staff to reduce the risk and maintain a person's safety and these were reviewed at least once a month. We saw when a person received oxygen therapy that this was monitored by staff and there was a sign on their bedroom door to alert others that oxygen was in use. One person told us, "I have oxygen all the time and the staff keep a good eye on things. They keep me safe and well."

We looked at five personal files for staff and saw that there were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. We spoke with a member of bank staff who was also an experienced registered nurse. They told us that they had received a very thorough induction from a senior member of staff before they were the registered nurse in charge of the service.

We found that there were sufficient staff on duty to meet people's needs and call bells were answered promptly. We noted that care staff did not rush people to get up in the morning or to eat their meals and staff took time to chat with people. People and their relatives told us that they had no concerns about staffing levels and there were always enough staff on duty. One relative said, "I come and go at all times and it's always the same. You never hear anything untoward [from staff] or buzzers ringing for a long period of time unattended." We observed that people who remained in their bedroom had access to call bells within their reach. One person who spent the majority of their time in bed said, "If I ever have to ring my bell they are here very quickly. I never have to wait long." Another person said, "Generally they have enough staff on and they usually answer the buzzer unless they have emergencies of course." The provider had a system for calculating the care dependency levels for the people who lived at the service. These dependency levels then informed the registered manager of how many staff with different skill levels were needed on each shift.

Good

Is the service effective?

Our findings

At our previous inspection in March 2016 we identified that care and treatment was provided without staff obtaining consent from the relevant person. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

On this inspection we found that staff asked people or their relevant person for consent before they provided care and treatment provider was no longer in breach of the regulation.

We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had given their signed consent to have their photograph taken for identification purposes and some had signed consent to reside at the service. However, we did not see a record of where a person had given consent to have a pressure mat at the side of their bed. We brought this to the registered manager's attention who told us that they would introduce this after our inspection. Where a person lacked capacity to give their consent staff followed the principles of 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. Records of best interest meetings recorded who had been involved in the decision making process, such as the person's family and health and social care professionals who had been involved in their care. For example, their social worker and community nurse.

We saw where a person had lacked capacity to consent to their care that they had appointed a member of their family to act as their Lasting Power of Attorney (LPA). A LPA is someone registered with the Office of the Public Guardian to make decisions on behalf of a person who is unable to do so themselves. However, some staff were unsure of the difference between a LPA for property and financial affairs and an LPA for health and welfare. We discussed this with the registered manager who told us that they would address this with staff as a priority.

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 had followed the requirements in the DoLS and several applications had been submitted to the local authority and five had been authorised and others were waiting for assessment. Furthermore, we saw that the provider had complied with the conditions of the DoLS. For example, one person required constant supervision for twelve hours a day. We saw that a member of staff was allocated to care for this person. We observed the staff member engage with the person in meaningful

activities and this supported the person to have a sense of belonging and security.
The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS. In addition, staff had the support of the clinical lead who was the designated MCA and DoLS lead and trainer for the service.

People and their relatives told us that staff had the knowledge and skills to carry out their roles and responsibilities effectively. One person said, "Oh the staff know what they are doing."

Staff were provided with a programme of training that supported a person's individual health and wellbeing needs such safe moving and handling and how to prevent a person from acquiring pressure damage and sore skin. In addition staff were provided with specialist training such as how to support a person living with memory difficulties to live a full and meaningful life. We saw that when staff attended a training course they completed a training book where they recorded what they had learnt and how they would use their learning to care for people. The registered manager checked their training books to ensure that staff could demonstrate that they had gained knowledge and understanding from the course. We saw that staff from all disciplines were provided with training pertinent to their specialism. For example a recently appointed member of the catering staff was undertaking a nationally recognised qualification in professional cooking.

Staff received regular supervision and appraisals and said that they were a positive experience and they welcomed feedback on their performance. We looked at supervision and appraisal records for two members of staff and we saw that their discussions were relevant to their role. For example, a registered nurse had discussed that they were preparing to revalidate with the Nursing and Midwifery Council to maintain their nurse registration.

People were provided with a well-balanced and nutritious diet. In addition, hot and cold drinks and snacks were provided throughout the day. People told us there was always plenty to eat and drink, that the food was good and that they had a choice. For example, one person said, "I like the food and there is always something that you like and I have a choice." Another person told us, "The food is very good and I always enjoy it."

People were given a choice of where they took their meals. Most people chose to take their meals in the dining room; however a few people preferred to take their meals in the lounge or their bedroom. People were supported to eat their meals without being disturbed. Some people told us that breakfast time was flexible and one person said, "I like to get up early for my breakfast and then I go back to bed for a while. We can be flexible like that."

We spoke with the cook who told us that they catered for people with special dietary needs and also fortified some dishes to support people who may be at risk of weight loss. When a person first moved into the service members of staff spent time with the person to discuss their food and drink likes and dislikes and any special dietary needs. There was a four week seasonal menu and the menus were discussed at residents meetings and people were encouraged to give their thoughts and feelings on the menus. When a new meal was introduced to the menu there was a trial session where people could taste the food to see if they liked it before it was permanently added to the menu. One person told us that it was time for a change of menu and said, "We haven't had a new dish for a while."

People had their risk of weight loss, obesity, malnutrition and dehydration assessed and had care plans in place to support their individual needs. In addition, people had their oral health needs assessed to ensure that their mouth was clean and free from sores and that their teeth were in good condition so as they were physically able to eat and drink.

People were supported to maintain good health and had access to healthcare services such as their GP, district nurse, speech and language therapist and dentist. People told us that they always saw a doctor when they needed one. One person said, "The doctor comes when they think I need him and they keep my family informed as well." Relatives told us that they felt reassured that staff would summon appropriate healthcare professionals if their loved one was unwell. For example one person's relative said, "They always keep me informed and let me know if [Name of person] needs the GP or is not very well or anything. I like the fact that they ring me if needs be. It reassures me." Visiting healthcare professionals told us that staff made timely referrals to their service, knew the healthcare needs of the person and followed the prescribed plan of care. People and their relatives had access to health and wellbeing information leaflets relevant to the health needs of people who lived at the service. For example, information on nutrition.

Good

Is the service caring?

Our findings

At our previous inspection in March 2016 we identified that people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which set out how they planned to address the areas highlighted
.
On this inspection we found that people were treated with dignity and respect by kind, caring and compassionate staff and the provider was no longer in breach of the regulation.

The clinical lead was also the designated dignity champion for the service. They were responsible for training staff and observing them in their care practices to ensure that people were treated with dignity and respect. We saw that people's right to their privacy and personal space was respected. For example, we noted that staff always knocked on a person's bedroom door before entering and doors and curtains were closed when a person was receiving personal care.

We observed that care and catering staff took a dignified approach at lunchtime. We found that when a person had their meals pureed that all food ingredients were presented separately and their meal looked appetising. We observed a member of care staff assist a person living with dementia who was reluctant to eat their meal. They staff member sat down beside them, supported them to eat their meal at their own pace and treated the person with dignity and respect and acknowledged their achievement.

People told us that they were looked after by kind, caring and compassionate staff. One person said, "I am very happy here. It's the best place ever. The staff are lovely, kind and courteous to me." Another person told us, "They are ever so good to me. They treat me to things." We later saw that the provider took this person out for lunch to their favourite fast food restaurant as a treat. When the person returned they told us that they had a wonderful time.

When the relatives we spoke with summed up the attitude of staff towards their loved one, they used words such as kind, caring, courteous and polite to describe them. One relative said, "They treat everyone with the best of respect. My relative is very well cared for." Another relative told us, "I am very happy with the care [name of person] receives here. I have complete peace of mind knowing that he is happy and well cared for."

We observed staff interacting with people and saw that people and staff had a good relationship and there was lots of friendly chat and laughter. When members of staff passed through the lounge area they acknowledged people and addressed them by name. We saw when a person called out, that a member of staff took time to sit with the person and listen to what they had to say.

We observed staff assist some people to the dining room or conservatory for their lunch. People were supported to walk at their own pace and staff chatted with them in a friendly manner. We saw that most

people sat in friendship groups to have their lunch. For most people lunchtime was a positive experience. The tables were set with napkins and table cloths and gentle music was playing in the background. However, one person with memory difficulties had become restless before their meal was served and asked their companions several times "what is happening". A member of staff sat with them and helped to calm them and then requested their meal from the dinner trolley.

We saw measures in place to enable people to be orientated to the day of the week and to their surroundings. For example, most bedroom doors looked the same. Therefore, people had a familiar photograph on the outside of their bedroom door to help them recognise their bedroom and reduced the risk of becoming distressed if they were unable to find their bedroom. Pictorial menus were on display in the dining room and this helped some people to make their choice at mealtimes. We observed a person who had difficulty explaining verbally what they wanted for lunch; make their choice by pointing to the pictures and smiling at the staff member. Some people told us that the night staff came to work in pyjamas. One person said, "Just lately we have the night staff ladies coming on in their pyjamas, so we know it's night time." We discussed this with the registered manager who said that they had appointed a new dementia specialist who worked with people and staff to improve the well-being of a person living with memory problems. They explained that sometimes people can be disorientated about the time of day and turned day into night. Staff wearing pyjamas acted as a visual prompt that it was night time and they had found that people who previously got up at night now returned to bed and their sleep pattern had improved.

The service had recently introduced and dignity and dementia support group with the aim of designated members of staff meeting with relatives of people who were living with dementia. The registered manager told us, "Some relatives don't understand what has happened to their parent or spouse. Some feel guilt ridden because they have put their loved on in a home. The feel they lost them when they were first diagnosed with dementia and now they have lost them again because they are in care. They feel helpless and that is where we hope to support them and give them some hope and encouragement." Attendance at the group was optional and the group had met three or four times in the last six months.

People had care plans tailored to meet their individual needs and we found evidence that people and their relatives were involved in developing their care plans. Care plans were person centred. One person's relatives said, "I know about the care plan and have been involved in it."

People were enabled and supported to maintain contact with family and friends and could receive visitors at any time, with the exception of mealtimes. This was so as people could eat their meal undisturbed unless it was beneficial for a relative or friend to be present. People could meet with their relatives in the main public areas or if they wanted a more private area then they could use their bedroom or the quiet lounge. One person commented about having visitors in their bedroom and said, "One thing that could be better is that they could have a chair in the bedroom for visitors to sit on."

People were provided with information on how to access an advocate to support them through complex decision making, such as moving into supported living in the community. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes.

The service often provided care to people who were near the end of their life. We saw that people had an advanced care plan that recorded the person's individual preferences for the care they wished to receive at the end of their life. For example, who they would want to be with them at the end or their funeral arrangements. We found that nursing and care staff were sensitive to the individual needs of the people in their care. The clinical lead was also a trainer in palliative care and supported staff to provide dignified care

to people at the end of their life.

Good

Is the service responsive?

Our findings

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was focussed on the individual person. People and their relatives were involved in planning their care. We saw that individual care plans focussed on supporting a person to live well and maintain their independence. One person's relative spoke of their involvement and said, "I was involved in the care plan when [Name of person] came in to the home, and we had a review a few months ago were we sat [with their key worker] and changed one or two things."

We found that people were encouraged to spend their time how and where they wished. We saw that some people chose to sit in one of the lounges or the conservatory whereas others preferred to return to their bedroom between meals. One person shared with us how staff supported them to follow a routine that suited them and said, "I don't go to bed, but my bedroom is upstairs, it's green, I chose the paint for my room, I like it. I sleep downstairs in a chair in the sitting room because I want to. The night staff come along and talk to me and bring me drinks and things during the night and I like that. I have my own cup and they always remember to bring me that one, its mine you see."

The people we spoke with told us that there was always plenty of things to occupy them and they never felt bored. For example, one person told us, "I have my newspaper delivered every day and I like to do the crossword although I'm not very good at it now. I forget you see. I have an awful memory." We noted that several people received a daily newspaper of their choice.

There was a weekly activity programme that reflected the individual preferences of people who lived at the service. We noted on the day of our inspection that people took part in private reading, board games, a song along and armchair exercises. Not everyone took part in organised activities. For example, one group of ladies sat together in the conservatory throughout the day and chatted and laughed with each other about the articles they were reading in their newspapers and magazines.

We saw that there were flower arrangements on all the dining tables. People told us that they had made them the previous day with support from the activity coordinator and some of the care staff. We saw that people were proud of their achievement. Between mealtimes a rummage box was placed on each table. The boxes contained items of interest to talk about or games to play with and was well used by people.

Some people invited us to look at their bedroom. We found that they were supported to personalise their bedroom with items from home such as pieces of furniture, photographs and keepsakes. One person who spent much of their time in their bedroom spoke with enthusiasm about the pleasure they got from watching the wildlife that visited the garden and said, "One of the best things is being able to see the squirrels and watch the wildlife in the garden. They [members of staff] are very good at feeding the birds. There are lots of things to watch in the garden."

People who lived at the service were invited to regular resident meetings with members of staff. We noted that the issues people raised were acted upon by the registered manager. One person told us, "We have

residents meetings and do have a say." We read the minutes from a dignity meeting with residents held on 7 December 2016. People had shared with staff their perception of what dignified care looked like. For example, one person said that the way staff phrased a question made a difference to how they felt and gave "Do you want or would you like", as an example. Twice a year people and their relatives were invited to take part in a satisfaction survey. We saw that comments and suggestions were generally positive. One person's relatives told us that they had been asked for their feedback on the service and said, "I was asked to complete a questionnaire last year about what we think as relatives."

People and their relatives told us that they would not hesitate to speak out if they were unhappy about anything. One person told us, "I have nothing to complain about. I would give the home 100%." One person's relative said, "If I wasn't happy about anything I would go to [Name of registered manager] in the office. She usually sorts things out straight away. She is good like that, sorts things out there and then." A copy of the complaints policy was on display in the main entrance hall and was also included in the service user's guide. Each person had a copy of the complaints procedure in their bedroom. The provider and registered manager followed a robust process to formally respond to complaints in a timely manner. We looked at two recent complaints and discussed them with the registered manager. We noted that they had been dealt with sensitively and the complainant had received a polite letter of response. The registered manager informed us that lessons learnt from the complaint were shared with staff and discussed at team meetings.

Good

Is the service well-led?

Our findings

We found that the registered manager was committed to making ongoing improvements to the service. When we found areas of concern we brought these to their attention and they were actioned straight away. For example, we noted that one person's air flow mattress was set at the wrong pressure. The mattress was found to be faulty and was replaced straight away. This fault was not present when a recent mattress audit was undertaken.

The registered manager was supported by the provider who visited the service at least once a week. The outcomes from all audits, complaints, accidents and incidents were shared with the provider.

The registered manager held regular meetings with individual staff groups and a held frequent general staff meetings. We looked at the minutes of meetings held in November and December 2016 and saw topics discussed included infection control, menu choice and training. Staff were positive about the meetings they attended and one staff member said, "All the staff are working well together. Some staff are really good and are coming to the table with new ideas." Other staff members told us that they had made suggestions to improve the quality of the care provided and these had been well received. The said that the registered manager recognised that changes were needed to improve the quality of care. For example, the seating layout in the main lounge and dining room had been rearranged to make smaller homely sitting areas. We found that this change had a positive impact on people who suffered with anxiety as they coped better in a small group. Overall, staff said that their contribution to changes in the service were valued and had positive outcomes.

We read the service's mission statement and their philosophy of care. We saw that both were person centred. The overall aim was that people felt valued, enabled to live a fulfilled life and maintain their independence. We saw a copy of the last inspection report with the rating on display at the main entrance.

We found that the registered manager was more visible than they had been on our previous inspections. They knew their staff and the people in their care. The people and their relatives that we spoke with knew who the registered manager was and knew them by name. People and their relatives told us that the registered manger and their deputy were approachable and they could pop into the office at any time to chat with them. One person said, "They are ever so good to me. I like the head lady. I don't remember her name. I just call her redhead."

Staff told us that they found the registered manager approachable and supportive. Furthermore, staff were aware of our last inspection report and could tell us that positive change had been introduced. One staff member said, "[Name of registered manager] is open and supportive. Since our last inspection they have taken on new ideas well and want to improve the home." Another member of staff said, "Recently we've had a lot of changes and they are for the better." Staff told us that the registered manager was a visible role model and was regularly "out on the floor." They added that the registered manager started their day by walking around the home first thing and had a chat with people.

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on delivering personal care. In addition, several members of staff had lead roles in topics such as cleanliness and infection control, tissue viability and safeguarding; to act as a resource to their colleagues.

Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager. We found that recent safeguarding concerns had been investigated by the registered manager and appropriate actions had been taken. The registered manager kept a log of all accidents and incidents that occurred in the service. Incidents and concerns and lessons learnt were shared with staff at team meetings and at supervision sessions.

The provider and registered manager had made significant improvements to their quality and audit programme. They undertook regular audits that covered key areas such as record keeping, health and safety, medicines and infection control. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff. We saw that where changes to practice were introduced as a result of audit outcomes that these were influenced by up to date national guidance and health and social care policies. For example, deep cleaning guidance for care homes and strategies and interventions to reduce the risk of falls.