Wellburn Care Homes Limited

Glenholme Residential Care Home

Inspection report

4 Park Avenue
Sunderland
SR6 9PU
Tel: 0191 549 2594
Website: www.wellburncare.co.uk

Date of inspection visit: 4 and 5 August 2015
Date of publication: 21/09/2015

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

Overall summary

This inspection took place on 4 August 2015 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 5 August 2015 and was announced. The service was last inspected in May 2013. At that time it met all of the standards that we inspected against.

Glenholme Residential Care Home provides care for up to 37 people some of whom have nursing care needs. The service is based in a two-storey converted Victorian townhouse, and bedrooms are located on both floors. There is a separate day centre adjoining the building.

At the time of the inspection there were 33 people using the service. 22 people had general nursing needs. Eight people were living with dementia.

Summary of findings

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

The accommodation was not specifically adapted for people living with dementia, even though the home provided this support.

People said they felt safe and comfortable at the home. Staff knew how to recognise and report any suspicions of abuse. Staff told us they would report any concerns to make sure people were protected. Potential risks to people's safety were assessed and managed. People's medicines were managed in a safe way although the security of the storage could be improved.

People told us there were enough staff to meet their care needs. Care professionals told us it was a "very good" service and staff were familiar with each person's individual needs. Staff attended quickly when people needed assistance. Staff were recruited in a safe way so that only suitable staff were employed.

The registered manager and staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision and deprivation of liberty safeguards to make sure they were not restricted unnecessarily. Staff asked for permission before carrying out care tasks. People told us they made their own choices over their own daily lifestyle.

Staff were knowledgeable about people's individual care needs and how they wanted to be assisted. People were supported to eat and drink enough and they had choices about their meals.

Health care professionals said the home responded quickly to any changes in people's well-being.

We saw that people were treated with dignity and respect. People were positive about the service, and were happy with the care that they received. Staff were well liked by people and their families. We saw that people were treated in a caring way. People were involved in decisions about their care and support.

The service did not advertise the role of advocates. No-one at the service required an advocate but we made a recommendation about this.

Care plans were comprehensive and gave a good insight into people's needs and how they would like them to be met. People's needs were assessed in detail, and were reviewed regularly. The plans contained details of personalised care, and we saw that staff were able to use these to deliver the care that people wanted.

The service employed an activities co-ordinator and we saw that people enjoyed the activities on offer. People and their families were able to give feedback on activities, and this was acted on. However, we saw that carers did not always have the time to join in with activities.

People knew how to raise complaints, and we saw that where this had happened they had been quickly and appropriately responded to.

Resident and family meetings were arranged regularly which gave people the opportunity to provide any feedback or share ideas, though we saw that these were not advertised within the service. The registered manager also sent people an annual questionnaire, and we saw that this had been used to improve the service. People and staff told us that issues they raised were sorted out quickly.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People felt safe at the home and with the staff who supported them. Staff knew how to report any concerns about the safety and welfare of people who lived there.

Risks to people were managed in a safe way so that people could lead as independent a lifestyle as possible.

There were enough staff to meet people's needs. The provider made sure only suitable staff were recruited. People's medicines were managed in the right way.

Good

Is the service effective?
The service was effective.

People felt the service met their individual needs and that staff were well trained.

Staff understood how to apply Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily, unless it was in their best interests.

People said the food was good quality. They were encouraged to have a good diet and plenty of drinks to help them stay as healthy as possible. People were helped to access other health care services when required, and the home staff worked well with those services.

Good

Is the service caring?
The service was caring.

We observed staff treated people with dignity, respect and kindness.

Staff were knowledgeable about people's needs, likes, interests and preferences. People were listened to and there were systems in place to obtain people's views about their care.

Good

Is the service responsive?
The service was responsive.

Care plans were comprehensive and captured people's preferences. People and their families were involved in care planning.

The service offered a wide-range of activities, including on a 1:1 basis, which people enjoyed. People and their families were involved in planning activities.

The service has a clear and well-advertised complaints procedure and people were confident that it would be followed. Where complaints did arise they were dealt with quickly and appropriately.

Good

Is the service well-led?
The service was well-led.

The registered manager and regional manager promoted the highest standards of care through regular audits.

Good

Summary of findings

Staff told us that they felt supported at the service and that their views were listened to.

There was a friendly and welcoming atmosphere at the service, and this was confirmed by the people we spoke to.

Glenholme Residential 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.

The inspection took place on 4 August 2015 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 5 August 2015 and was announced.

The inspection team consisted of two adult social care inspectors, a specialist adviser 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.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners of the service, the local authority safeguarding team and external professionals involved in the service.

During the inspection we spoke with 15 people who lived at the service and six relatives. We spoke with 16 members of staff, including the registered manager, the deputy manager, the regional manager, senior care staff, carers, the cook, household staff and the activities co-ordinator. We also spoke with two external professionals who were visiting the service.

We looked at 12 people's care records and 35 medicine records. We reviewed six staff files, including recruitment processes. We reviewed the supervision and training reports as well as records relating to the management of the service.

We looked around the building and spent time in the communal areas.

Good

Is the service safe?

Our findings

People told us they felt very safe living in the home and comfortable with the staff who supported them. One person commented, "Staff are hard-working but relaxed and friendly and I get choice over what I want to do." Relatives also felt the home was a safe place for people and were very complimentary about the staff. One relative told us, "My [family member] is happy and content here and that is very comforting."

Staff had a good understanding of how to respond to safeguarding concerns. All the staff we spoke with said they would not hesitate to report any concerns or incidents of abuse. Staff were able to describe the different signs of abuse and knew how to raise any concerns immediately. The registered manager had notified the local authority, and CQC, of any safeguarding incidents and had taken appropriate action when this was required.

Staff told us, and records confirmed, they received training in safeguarding vulnerable adults. All staff, including ancillary staff, had access to the safeguarding policy and the telephone number of the local authority if they needed to contact the council directly. Each member of staff also discussed their understanding of safeguarding at their regular supervision sessions with their line supervisor. In this way all staff were aware of their responsibility to protect the people who lived there and to report any concerns.

Risks to people's safety and health were appropriately assessed, managed and reviewed. There were risk assessments about people's potential for falls, pressure damage to their skin and using moving and assisting equipment. The assessments included plans about how to reduce the potential risks to the person. For example, motion sensors linked to the nurse call system had been put in place for a couple of people who might get up through the night. This meant staff could be alerted to their movement and quickly support them. Risk assessment records were personalised for each person, up to date and were reviewed monthly or more often if people's needs changed.

There was a business continuity file at the front entrance with important information about people, services and support that staff could access in the event of an emergency. This included some information about how people would need support to evacuate the building in the event of an emergency. However there were no specific 'personal emergency evacuation plans' (PEEPS) in place which would include information on each person's mobility as well as any specialist equipment that might be needed to support an evacuation. We saw that the information was available in other records. The regional manager acknowledged this and stated this information would be used to write individual PEEPS.

The provider employed a member of maintenance staff who visited the home around two days a week to carry out any regular premises checks, such as fire safety and hot water checks, and attend to any minor repairs or decoration. The standard of accommodation was good and all areas that we viewed were safely maintained. We did note a small number of minor premises issues that could present a potential risk. These were addressed immediately when we reported them to the regional manager. For example, one freestanding heater in a lounge had a hot surface temperature so could present a potential risk if a person held it for a while. This was dealt with immediately. We also noted that the bedroom door of a person who was bedfast was held open by a decorative door-stop rather than a specific fire safety door guard (which would release the door in the event of a fire alarm). A door guard was fitted the next day. One corridor had areas where the surface was uneven which could have presented a risk of tripping. This was also dealt with the next day.

The temperature of water to baths and washbasins had become increasingly cool over the past few months and this had been identified during regular maintenance checks. As a consequence the provider was arranging for an additional boiler to be installed that would serve the ground floor extension so that hot water could be maintained at a satisfactory temperature in all areas of the home. In this way any issues were identified and addressed by the provider.

People, relatives and health care professionals felt there were enough staff to support the people who lived at the home. The staff on duty were visible around the home and spent much of their time in or near the lounges, so they were often already present if people needed assistance. There were call alarms in all bedrooms and communal areas so that people could summon support wherever they

Good

Is the service safe?

were. Throughout this inspection there were only a small number of occasions when the call alarm sounded, and these were responded to quickly by staff. This meant people received support in a timely way.

A visiting health care professional told us, "There are always staff available to assist when I visit. And if I need to ask them anything about the person I press the buzzer and they come immediately to help."

We saw that staff spent time talking with people and their visitors. In discussions staff were very knowledgeable about people's needs and preferences. Most of the staff had worked in the home for several years and were familiar with people's well-being. This meant they were able to pass on information to visiting relatives about any changes in the health of their family member. Relatives told us staff were informative and friendly. One relative told us, "The staff are really good. They know about the needs of everyone and are pleasant and helpful."

The registered manager described how staffing levels were determined based on the dependency needs of the people who lived at the home. At the time of this inspection there were five care staff on duty, including two team leaders (senior care staff) and three care workers. This would reduce to one team leader and three care workers in the evening. Overnight there was one team leader and two care workers. One staff member told us, "There are enough staff most of the time, but sometimes there are only four of us due to sickness or holidays. This makes it hard on staff – but not unsafe for the residents. And we can always ask for help from the domestic who is trained in care."

The home had a low turnover of care and ancillary staff, and there had been only four changes to staff in the past three years. At this time there was one vacancy for a part-time care worker and these hours were being covered by existing and relief staff. The registered manager explained that she preferred not to use agency staff unless it was critically necessary. This was because existing staff were familiar with people's needs and would be aware of any changes in their well-being.

We looked at recruitment records for four staff members. We found that recruitment practices were thorough and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the home had checks in place to make sure that staff were suitable to work with vulnerable people.

The arrangements for managing people's medicines were safe. The senior staff who are responsible for medicines had received suitable training in managing these in a safe way. They had regular competency checks by the registered manager to make sure they were still carrying this out in the right way. We saw the people were supported with any medicines in a sensitive manner. The senior staff took the medicines to each person rather than dispense it from a trolley. It was good practice that staff did not set dosage times for 'as and when' medicines. This meant staff were asking people and making judgements whenever people needed those medicines, rather than at standardised times.

We looked at the medicines administration records (MARs) for all the people using the service. We saw photographs were attached to people's medicines administration records (MAR) so staff were able to identify the person before they administered their medicines. The MARs also included any allergies and details of their GP. There were records of any medicines omitted and the reasons why these had not been administered. The registered manager completed in-house audits of medicines and the regional manager audited these as part of the monthly visits to the home.

Medicines were stored in lockable trolley in a treatment room with an alarmed door. The provider's medicines policy stated that the trolley and treatment room door must always be kept locked. However, on the day of this inspection, we noted that the trolley was left open (although inside the treatment room) when it was being used. The regional manager acknowledged this should be kept locked at all times.

Good

Is the service effective?

Our findings

People told us staff understood their needs and supported them in the right way. People and visitors described the care service as "very good". One relative commented, "The family are very happy with the care given." Another visitor told us, "The staff are spot on." A visiting health care professional commented, "This home provides very good care, and reliable care for people with palliative care needs."

People said they thought staff were skilled in their jobs. Staff told us, and records confirmed, they received necessary training in health and safety matters, such as first aid, fire safety, food hygiene and infection control. Eleven of the 16 members of care staff had completed a national qualification in care, such as NVQ level 2 or a diploma in health and social care. One member of staff told us, "We get lots of training. I've recently done training in dementia awareness, diabetes and end of life. I can ask for any training at my supervisions."

We looked at how the provider supported the development of staff through supervisions. Supervisions are regular meetings between a staff member and their supervisor, to discuss how their work is progressing and where both parties can raise any issues to do with their role or about the people they provide care for. The care staff we spoke with said they received regular supervision from the registered manager. Ancillary staff received supervision from their line supervisor. All staff had an annual appraisal with the registered manager. A care staff member told us, "We have one-to-ones every couple of months. We discuss any issues and any training I'd like. I feel I can speak honestly. " It was good practice that the one-to-one records included a space for staff to make suggestions "to improve the residents' experience or help in the running of the home".

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The registered manager was aware of DoLS to make sure people were not restricted unnecessarily, unless it was in their best interests. She had made DoLS applications to the local authority in respect of people who needed supervision and support at all times. At the time of this inspection nine DoLS applications had been authorised by the local authority and more applications were pending. This meant the home was working collaboratively with the local authority to ensure people's best interests were protected without compromising their rights.

The registered manager and staff were clear about the principles of the Mental Capacity Act 2005. There were assessment records about the capacity of individual people to make their own major decisions (for example, whether to consent to the inclusion of their photograph in their care records) and records of best interest meetings where they did not have capacity to consent to this. The home had involved relevant persons to represent people who did not have capacity to make these decisions. We saw people were asked for their permission before being supported. For example, staff asked people if they could carry out a care task and also encouraged them to be as independent as possible

People were very complimentary about the quality and choices of meals. They described meals as "excellent" and "very good". We joined people for a lunchtime meal in the two dining rooms. There were menus on the tables for people to choose from. People were asked for their preferences at the time of the meal. They were shown plates containing the two main choices so they could make an informed decision. The meal was served promptly so people did not have to wait. During the meal care workers were supportive and engaged with people, encouraging them to enjoy their meal and promoting their independent skills (for example, reminding them to cut their food up if necessary). Some people required physical assistance with their meal and this was carried out in a sensitive manner and at the person's own pace. We noted that a visiting relative was invited to join people for their meal and all visitors were offered drinks. Another relative told us, "The food is good. I can visit anytime and I am always made very welcome and offered a cup of tea."

People were supported to eat and drink enough to meet their nutrition and hydration needs. They were offered a variety of snacks and drinks every couple of hours in between main meals and there were jugs of juice and glasses in the lounges so that people could help themselves whenever they wanted. One person told us, "If I can't manage to finish my main meal I know that there's crisps, cake and fruit off the trolley later!"

The cook had worked at the home for over 20 years and was still passionate about supporting people to enjoy good

Good

Is the service effective?

quality, home-cooked meals. She told us, "The owners are very generous about the food and choice of menus. They have to have budgets but people get whatever they want to eat and it's all good quality." The catering staff were very knowledgeable about people's individual dietary needs, for example whether they required their food to be softened and whether they needed a fortified diet to build them up.

Relatives felt people were supported with their health care needs. They told us that they were kept informed if their family member was ill. They also confirmed that they had been involved in the care planning for their relative.

People were helped to access other health care services whenever this was required, and the home staff worked well with those services. People's care records showed when other health professionals visited people, such as their GP, dentist, optician, podiatrist and dietitian. A visiting healthcare professional told us, "The staff here are very good at early anticipation of a change in people's needs. They contact us whenever they need to and always ask our opinion and take our advice."

Glenholme care home was a Victorian building that had been adapted and extended a number of times over the years. It was a comfortable but complex building to navigate. Most of the people who lived at this home had a diagnosis of dementia or memory loss. There was little in the way of design to support the orientation of people who may forget their way around the building. For example, all the doors were white so people may not be able to differentiate between bedrooms, offices or store cupboards. A small number of bedrooms had 'memory boxes' with mementos and familiar objects to help those people remember their own room. However there were no other visual clues for people to find different areas of the building. The regional manager agreed and stated that picture signage had been ordered to support people's orientation around the home

Good

Is the service caring?

Our findings

People we spoke to were positive about the care they received and told us they were happy at the service. One person told us, "I am happy here, it is good". Another said, "I like my room, staff are hardworking but relaxed and friendly and I get choice over what I want to do". We observed that staff spoke with people in a friendly way as they were moving around the service doing their work, and often stopped to talk to them and their relatives. One member of staff told us, "We try and spend as much time as possible on the floor with residents. It can be busy but the girls try as much as possible to have 1:1 time". Another said, "I have got to know people here. I like chatting to them all, like to ask about their pasts and families. It's amazing what you get to know and that's what I find interesting about the job". A visiting health care professional told us, "People always look well-cared for and are treated with dignity. If anyone spills anything at mealtimes they are helped to change straight away."

We saw that staff, including the registered manager and area manager, knew people well and that people were happy to talk to them. For example, during lunch staff recognised where people had dietary needs and their preferences.

People's privacy and dignity was respected and promoted. Where people needed help and support we noted that staff asked them in a discreet and caring way, explained what options people had and encouraged them to do things for themselves. For example, during lunchtime one person who needed assistance with eating was asked whether they wanted to use a protective apron. They said, "I would rather try to eat without one as I think they are not dignified", which led staff to encourage the person to eat without one and reassure them they could easily deal with any food that was spilt. In another example, we saw that the activities co-ordinator adapted an exercise activity by focussing more on recall exercises for those we were less physically able so that they still felt included.

The 'Service Users Guide', a copy of which was available in each person's room, contained a policy covering privacy and dignity. It included, 'Privacy: the right of a resident to be left alone and undisturbed whenever they wish. Dignity: The understanding of a residents needs and treating them with respect'. Staff had a working knowledge of the policy. One told us, "It's the way we are with them, carers have to treat them as individuals". Another said, "Respect is the way you treat people. Dignity is about making them feel they can do things for themselves".

Visitors we spoke to were positive about the service and felt included in the care of their relatives. One visitor said, "The family are very happy with the care given. Staff are pleasant and helpful and the food is really good. There are no worries here". Another said, "This home is great and I have an idea of what that is as I have visited quite a few. The staff are great…" A letter of thanks sent to the service by a relative read, '[The registered manager] and staff are a credit to your profession'.

The registered manager told us that no one at the home currently had an advocate supporting them. We noted that the service did not advertise advocacy support or inform people about external agencies that could support a person if an advocate was required. We suggested to the registered manager that such services should be advertised and were told that this change would be made.

Good

Is the service responsive?

Our findings

Most of the care plans we looked at were comprehensive, and included assessments for weight and nutrition, skin integrity, falls and mobility, moving and handling, choking, and general risk assessments. These had been clearly and fully completed, and we saw that they were regularly evaluated. The care plans also contained evidence where referrals to other professionals involved in people's care had been requested. For example doctors, the district nurse, the community mental health team, staff from the memory clinic and the challenging behaviour team, tissue viability specialist nurses, dieticians and speech and language staff. Their visits and advice were clearly documented in care plans and where the outcomes from advice followed were recorded.

At the front of the care plan there was comprehensive information about the person's individual needs and preferences, which gave a good insight into how they would like them to be met. There was also a 'hospital passport' which included the same information to ensure continuity of care if they were admitted to hospital. People and their visitors felt individual needs were being met by the service. One visitor said, "the staff are really good, they know about the needs of everyone and are pleasant and helpful".

There was a well-established staff team who had been working in the service for a number of years and were able to talk to us about people's individual needs, who visited them and their usual routine. We saw that staff knew people's visitors, and included them in conversations about people's care.

We found that there was some inconsistency in the level of detail recorded in the care plans for people using the service for respite care. Personal details and medical details were recorded, and nutrition, medication, circulation and breathing, communication and sensory, continence, personal hygiene, moving and handling, skin integrity and sleep and night support assessments were carried out. However, the 'Record of Professional Contact' and 'Life History' records were not always completed and the discharge date was not always recorded. We asked the area manager about this and were told that the service was moving towards using the same assessments for respite care as were used for permanent residents and that staff had been reminded not to leave records blank.

Staff told us that they involved people and their families in planning their care. One told us, "Senior staff and the manager do care plans. We involve families and residents. We interact with residents to see what should be in it". One relative told us, "There is plenty of choice, for example getting up and going to bed, what to eat, what to do".

The service put an emphasis on activities. An activities co-ordinator was employed for four days a week. He told us the days he worked were flexible which meant that he was able to undertake activities during the week and at weekends. We saw that there was a monthly activity plan and that something was arranged every day. The plan was placed in every person's room, though we noted that it was not displayed elsewhere in the home and there was no notice of what a day's particular activity was.

There was a wide-variety of activities on offer, including quizzes, films nights, sing-alongs, reminiscence sessions, pub nights and exercises. The service had access to the mini-buses of the adjacent day centre, and we saw that there were several trips a month in the local area. One person told us, "We do go out in the bus and the outings are very enjoyable". The activities co-ordinator undertook individual activities with people who could not or did not want to participate in group sessions, and was able to name people he worked with in that way and the activities they enjoyed. During the inspection we saw an aromatherapist, whom the service pays to make a weekly visit. A visiting health care professional told us, "There's always something going on in terms of activities".

People had the opportunity to give feedback at the end of an activity. We saw that the activities co-ordinator attended resident and family meetings for further suggestions, and that people and their relatives were involved in planning activities. We saw that they attended a meeting on 19 March 2015 at which various suggestions for trips were made, and that some of these had been arranged later in the year. At a meeting on 4 February 2015 it was agreed that, 'there was going to be a big push on fundraising to ensure that the residents were able to enjoy various activities'. One visitor told us, "The activities organiser works very hard and is really good. Everyone seems to enjoy his sessions and on a Saturday he often organises something in the day centre as it is bigger. I have had a

Good

Is the service responsive?

dance in there". The activities co-ordinator told us that they felt supported by management in developing and delivering activities, adding, "[the registered manager] looks after the budget but anything I want I can get really".

The service had a complaints policy. People had a copy of this in their room and it was displayed outside of the registered manager's office. We saw that complaints were monitored on a monthly basis, and that a trend analysis took place every six months. We saw that four complaints had been made in the last six months. In each case the complaint was investigated and dealt with quickly, appropriately and with remedial action where necessary. Complaint trends were analysed, and where necessary remedial action was taken. For example, when the analysis identified that housekeeping issues were arising just before the housekeeping shift ended staff had their finishing times altered to ensure appropriate cover. People and visitors told us they knew how to complain but had no reason to do so.

Good

Is the service well-led?

Our findings

We saw that the registered manager undertook a number of audits to monitor and improve the service. These included a 'Manager's Weekly Audit' and monthly audits of mattresses, the kitchen, health and safety, care plans, medication, accidents, weights, falls, continence, 'meal service' and 'Key Performance Indicators'. In addition, the registered manager undertook night spot checks. The housekeeper also carried out a monthly audit of premises and general cleanliness. We saw that these audits had been analysed for trends and, where necessary, used to make improvements at the service. For example, the falls audit of 4 June 2015 recommended that all staff attend falls training by the end of the month and we saw that this had been done. We also saw that analysis of the weights audits led to appropriate referrals to the SALT team and dieticians.

We looked at service records, including PAT, legionella risk assessments, hazardous waste certificates, electrical installation certificates, gas safety certificates, lift safety services, Lifting Operations Lifting Equipment Regulations 1998 (LOLER) servicing for hoists, calibration of seated scales documentation, emergency lighting checks, fire sprinkler checks, thermostatic valves and fire alarm maintenance checks. These had all been completed correctly and were in date.

The area manager also undertook a monthly audit of the service. Where issues were identified an action plan was generated, which was checked for progress at the time of the next visit. For example, the June 2015 visit identified that only two fire alarm tests had been undertaken in May when this should have been done weekly. We noted that the resulting action plan required weekly fire alarm tests and that this had been carried out. The area manager told us that she visited the service "constantly" and we saw that she knew people and their visitors. She told us, "When I do an action plan, I check up on it".

We were told that staff meetings took place at least once every two months, but more frequently if specific issues needed to be discussed. We looked at minutes from staff meetings and these showed that a range of issues were discussed, including a reminder of policies and any feedback that the service had received. Staff also told us that they had regular handover meetings and conversations. They told us that they felt supported in their roles and confident to raise any issues that they had. One member of staff told us, "[the registered manager] is good, any problems and she'll sort it out". Another said, "Staff meetings are good to sit down and get things off your chest". The registered manager told us, "We have worked together long enough that they'd tell me if they had problems".

The service undertakes an annual survey of what people think of the survey, and we saw that the most recent one took place in February 2015. 30 people responded to the questionnaire. 28 people rated the 'overall service in the Home' as 'excellent', and 2 rated it as 'good'. We saw that an action plan had been put in place to investigate any answers of 'fair' or 'poor'. Only one rating of poor was given, to the question 'do you like the food in the home?' The action plan stated, 'resident who rated it poor admits they are a very fussy eater, but has a menu that he picks day to day to whatever he prefers'. Five people answered no to the question 'can you make a telephone call in your room?' The action plan stated, '[The registered manager] to make all families aware that there is capability to make phone calls but it is their responsibility to arrange connection with BT etc.', and we saw that this advice was also contained in the 'Service Users Guide'.

Resident and family meetings were arranged regularly which gave people the opportunity to provide any feedback or share ideas, though we saw that these were not advertised within the service. We looked at the minutes of resident and family meetings and saw that people had the opportunity to give feedback and ask questions. Where specific issues were raised, we saw that an action plan was generated which the registered manager was responsible for delivering. During one meeting there was a request for 'an increase in activities within Glenholme including musical activities and exercise classes'. The action plan showed that the service had, 'employed an activity co-ordinator who is dedicated in planning and organising activities…this includes [the activities co-ordinator] being a qualified [exercise]instructor and holding twice weekly exercise classes, regular musical quizzes and musical activities'.

The registered manager understood her responsibilities. We noted that all relevant notifications concerning running the service had been made to the Care Quality Commission. The registered manager told us that she saw the area manager once a week, and said, "I am supported by head office". She attended bi-monthly regional service

Good

Is the service well-led?

meetings, which she thought were a good opportunity to, "share practice and experience". A visiting health care professional told us, "The manager is very much on the ball. We have an excellent, honest and open relationship. She is always willing to discuss any issues and work with us to resolve them".