The Boyne Care Home Limited

The Boyne Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 23 and 24 November 2015 and the first day was unannounced. The last inspection took place on 30 June 2014 and the provider was compliant with the regulations we checked.

The Boyne Residential Care Home provides accommodation for a maximum of 25 older people with dementia care needs. At the time of inspection there were no vacancies.

The service is required to have a registered manager in post, and there is a registered manager for this service. 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.

Summary of findings

People confirmed they were happy living at the service and feedback from people, relatives and visiting healthcare professionals confirmed the service was well run and people's changing needs were being identified and met.

Safeguarding and whistleblowing procedures were in place and staff understood these and were clear to report any suspicions of abuse. The complaints procedure was displayed in the service and people and relatives were encouraged to express their views. They were confident they could raise any issues and that these would be addressed.

Risks were assessed for people and also for any areas of risk within the service so these were identified and action plans put in place to minimise them.

Staff recruitment procedures were in place and were being followed to ensure only suitable staff were employed at the service. The service was appropriately staffed to meet people's needs.

Medicines were being well managed at the service and people were receiving their medicines as prescribed.

People's nutritional needs and preferences were being identified and met. Input from healthcare professionals was provided to monitor and address people's health needs.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted.

Staff received training and demonstrated a good understanding of people's individual needs and wishes and how to meet these effectively. Staff supported people in a gentle, calm and friendly way and respected their privacy and dignity.

Care records reflected people's needs, choices and interests and were kept up to date and staff understood people's changing care and support needs and provided person-centred care. People's religious and social needs were identified and were being met.

Systems were in place for monitoring the service and these were effective so action could be taken promptly to address any issues identified. The service used good practice guidance and research to identify and make improvements the service provided to people.

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?

Good

The service was safe. The provider had arrangements in place to safeguard people against the risk of abuse.

Staff recruitment procedures were in place and being followed. The service was being staffed to meet the needs of the people who lived there.

People told us they were happy living at the service. Risk assessments were in place for any identified areas of risk and were kept up to date.

Medicines were being well managed at the service and people were receiving their medicines as prescribed.

Is the service effective?

Good

The service was effective. Staff received training to provide them with the skills and knowledge to care for people effectively, and we saw this in the support staff provided to people.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff acted in people's best interests to ensure their freedom was not unduly restricted.

People's nutritional and dietary preferences and needs were identified and were being met.

People's healthcare needs were monitored and they were referred to the GP and other healthcare professionals as required.

Is the service caring?

Good

The service was caring. Staff listened to people and provided care and support in a gentle, calm and friendly way, putting people at ease and gaining their trust.

People and their representatives were involved with making decisions about their care. Staff understood the support and care each person required and treated them with dignity and respect.

Is the service responsive?

Good

The service was responsive. Care plans were in place and had been reviewed each month to reflect any changes in people's needs, so staff could meet them.

People's religious and cultural needs were identified and being met. Activities took place to meet people's interests and abilities.

People and relatives were encouraged to raise any concerns and were confident these would be addressed.

Is the service well-led?

Good

The service was well-led. The service had a registered manager and nominated individual who were supportive and a staff team who worked together well.

Summary of findings

Meetings took place and surveys were carried out for people, relatives and staff to express their views about the service. Action was taken to address any points identified for improvement.

There were systems in place to monitor the quality of the service, so areas for improvements could be identified and addressed. Good practice guidance and research was accessed and used to inform and improve the service provision.

The Boyne 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 was carried out on 23 and 24 November 2015 and the first day was unannounced. The inspection was carried out by three inspectors on the first day and one inspector on the second day.

Before the inspection we reviewed the information we held about the service including the last inspection report, information received from the local authority and notifications. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

During the inspection we viewed a variety of records including four people's care records, daily monitoring records for 25 people, three staff files, medicines administration records for 12 people, servicing and maintenance records for equipment and the premises, risk assessments, audit reports and policies and procedures. We observed interaction between people using the service and staff throughout the inspection.

We spoke with nine people using the service, eight relatives, the nominated individual, the registered manager, two team leaders, three care staff, the cook and the activities coordinator. We also spoke with the hairdresser, the external trainer and two healthcare professionals, those being the optician and the GP for the service.

Good

Is the service safe?

Our findings

People confirmed they felt safe at the service. Comments included, "I feel safe enough,"

"I would recommend it here" and "It's fine here." Relatives also said they felt the service kept their family member safe. One commented, "Here is absolutely fine, very good. It's clean here and [relative] is safe."

People were protected from the risk of abuse. The safeguarding procedure was displayed in the service in an easy to read format, so the information was accessible to everyone. The procedure was also discussed at each residents meeting so people were familiar with it and encouraged to report any worries. Staff understood the safeguarding policy, had received training and updates on safeguarding and were able to describe the various types of abuse that people could be at risk of including physical, financial, sexual, neglect and emotional abuse. Staff also mentioned the risk of institutional abuse, whereby people could be unreasonably required to follow rules designed to suit the management of services rather than for their own needs and preferences. We asked staff what they would do if they were concerned about the behaviour of other staff or saw an unexplained injury on a person. Staff were clear about the need to document evidence and report this to their team leader or manager and that they had a duty to report the matter externally, for example to the local authority, should they feel that the provider was not taking concerns seriously. Where the service handled monies on behalf of people, procedures were in place and being followed and we saw clear records were maintained for monies received and spent and receipts for all items or services purchased. This provided a clear audit trail and record of income and expenditure for each person.

Risks were identified so action could be taken to minimise them. Risk assessments were in place for identified risk to individuals. These included the use of bedrails, outings, moving and handling, falls, ability to use a call bell and administration of medicines. All risk assessments had been reviewed monthly and were up to date. Personal emergency evacuation plans (PEEPs) were in place in case the building needed to be evacuated, for example, in the event of fire. We saw fire evacuation equipment on each floor including evacuation slides. There was a symbol on each person's bedroom door coloured green, amber or red, indicating the level of assistance each person needed if evacuation of the service was required. Risk assessments had also been completed for use of equipment and safe working practices in the service, for example, use of kitchen equipment, working at height and slips, trips and falls hazards. These were reviewed every three months to keep the information current.

Accidents and incidents were recorded and reported, however although these were reviewed, information about monitoring was brief. Action was taken during the inspection to make the system of accident and incident monitoring more comprehensive and robust so any trends could be identified and used to review practices, for example, staffing deployment. We viewed a sample of equipment servicing and maintenance records. Equipment including the hoist, lift, gas appliances, and the fire alarm and emergency lighting systems had been checked and maintained at the required intervals, to ensure these were safe. There was a business continuity plan in place and this included contingency arrangements for any emergency situations or loss of services, so people would be kept safe.

Recruitment procedures were in place and being followed so that only suitable staff were employed at the service. Application forms and medical questionnaires had been completed and explanations recorded for any gaps in employment histories. A photograph was on file and checks including proof of identity, right to work in the UK and references were obtained, including from previous employers. Disclosure and Barring Service (DBS) checks had been carried out. Staff said they were required to fill in a job application form and provide two references including one from their most recent employer. Staff said they had been interviewed by two people and their references had been taken up before they were offered the job. Staff confirmed that they were not able to start work until DBS checks had been undertaken. The home was being appropriately staffed to meet people's needs. The staff rota was up to date and any changes had been recorded and cover provided for absence. The service used their own staff to cover for shortages and the registered manager said they had been a little stretched recently due to long term sickness and booked leave. The registered manager was happy to work hands-on if necessary and the nominated individual was also an experienced manager, so was able to fulfil that role temporarily if required. We saw

Good

Is the service safe?

that any staffing concerns were addressed to ensure staffing levels were maintained. Staff worked well as a team and people did not have to wait long for their needs to be met and call bells were responded to promptly.

Systems were in place for managing medicines and people received their medicines as prescribed. The service used a monitored dosage (MDS) 'pod' system and medicines were supplied in 28 day packs, each of which had a photograph of the person and the contents listed on it. Receipts of medicines had been checked in by two staff who had signed to confirm this. We carried out a stock check of eight blister packs and five boxed medicines and records and stocks were correct. Medicine administration record charts (MARs) were complete and up to date. Boxed and liquid medicines had been dated when opened and stock balances of boxed medicines were recorded daily. This was to ensure stocks were maintained and expiry dates could be adhered to. The service had the required secure storage for controlled drugs, however no-one was being prescribed these at the time of inspection. The temperatures of the room where medicines were stored and the medicines fridge were checked and recorded twice a day to ensure medicines were being stored at safe temperatures. When people needed their medicines to be administered covertly, risk assessments and care plans were in place for this and there was written authorisation from the GP held alongside the MAR, so staff had clear instructions for this.

Care plans for pain control were in place providing staff with the information they needed to identify when people required pain control medicines to be administered. The majority of people were able to communicate when they required these medicines and confirmed they received their medicines as needed. Staff involved with giving medicines were able to describe how they identified if someone who was not able to communicate verbally might express they were in pain, for example, by observing their facial expression and body language. This was in line with the Abby Pain Scale, a recognised assessment tool for the measurement of pain in people with dementia who cannot verbalise, which was available for use where required. One staff member said, "Watch every movement, body language is important. We observe and inform the GP." Policies and procedures for the management of medicines were in place and included specific instruction relevant to the MDS system in use, so staff had clear information to refer to. Staff involved with the administration of medicines had received training in medicines management. This was confirmed by staff we spoke with and in the training records we viewed.

The communal areas, corridors, bathrooms and people's rooms were clean and the service was fresh throughout. Each bathroom contained a supply of aprons and gloves so staff had access to the personal protective equipment they needed when providing personal care. Cleaning schedules identified the frequency of cleaning of each area or item of equipment and these were being followed.

Good

Is the service effective?

Our findings

One person told us, “The food is very satisfactory.” Another said, “This place, the food, everything is very good. It's lovely and clean. They really do treat us very well. I have my own room and am very happy.” Comments from relatives included, “Everything is very good so far. My [relative] settled in very well” and “We usually go into the dining room but I think it was very busy today. [Relative] seems well looked after. [Relative] is always clean and tidy and seems calm and happy.”

Staff received the training and support they needed to care for people effectively. We asked staff about the training they received. Comments included, “I had a lot of experience having just left a similar job. So my induction was not so long as I had all the training certificates up to date. But I still did the shadowing on each shift before working alone” and “I did a week shadowing another member of staff.” Some of the staff we spoke with had joined the service within the last six months. They were able to describe the induction programme which included training on topics such as safeguarding, fire safety, first aid, infection control and providing personal care. They had also shadowed experienced staff on day and night shifts to observe and gain experience in the care and support people required. Staff said they felt they received good training from the provider. Staff said in recent months training courses had included fire safety, manual handling, food hygiene, infection control, dementia and palliative care. Staff were confident that they had the skills and knowledge to provide the care and support people needed.

We spoke with the external trainer who told us they attended the service each month to carry out mandatory training using interactive methods and tailoring information to the situation staff were likely to have experienced. They said the provider was diligent in ensuring that staff had access to regular training. They told us, “Staff are generally well equipped. They participate well in training and are usually very keen.” Staff records evidenced the training staff had undertaken, including Skills for Care induction training programmes and training and updates in health and safety and a wide variety of topics relevant to the care and support of the people using the service. Staff had quarterly individual supervision sessions. We asked staff to describe issues raised and it was clear that the meetings they referred to were a meaningful and useful opportunity to review their practice. For example, one member of staff told us that the meeting reviewed their strengths and also identified areas where their practice could be further improved. They were also monthly group supervisions where different topics were discussed, for example, effective communication, choking, infection control and abuse awareness. Staff also had an annual appraisal to do a full review and identify areas for development. This meant staff were kept up to date with good practice developments and given the opportunity to improve their knowledge and skills.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). At the time of inspection 20 people using the service were subject to DoLS authorisations and three were awaiting assessment. The registered manager explained when people were first admitted to the service they took time to observe them and identify their level of capacity and would then apply for DoLS as appropriate. There was a register for DoLS in place and this identified each person in the service, if a DoLS had been applied for, the approval date and when it was due for renewal. Where appropriate, DoLS were also in place for people who had been to the service for temporary respite care and this showed DoLS were considered for everyone using the service.

Care records confirmed Mental Health Capacity Assessments and Best Interests Assessments had been carried out. We found evidence of Best Interest Meetings being held with families and these were recorded in Contact with Family Members Records. People had Lasting Power of Attorneys (LPA) and Deputies appointed by the court (AD). This had been checked and confirmed during

Good

Is the service effective?

the pre-admission processes. People's right to choose was respected. Care records contained consent forms signed by LPAs and ADs agreeing to different aspects of care. These included consent for a photo to be taken, consent to share a room or consent for bedroom doors to be locked or unlocked. Do Not Actively Resuscitate (DNAR) forms had been completed for seven people using the service. All forms were placed clearly in the front of the care records, were signed by the GP and had the reason for arrangement and evidence of discussion with the family completed, so the reason for the decision was clear.

Staff had received MCA and DoLS training. They told us about how they ensured people were able to make decisions about their care whenever they were able to do so. One member of staff told us how they helped people to communicate. They said, "It is important not to jump to conclusions about what people want and to ask open-ended questions, keep eye contact and speak slowly." Staff were clear about the importance of people consenting to their care. One staff member said that when people said no this had to be respected "even if they had previously agreed to something in their care plan, on the day if they say 'no', no means no." Other comments from staff included, "If someone refused care or didn't want their meal we can come back later and ask again. We do this a lot here" and "There are a few people who can be challenging. One person we have to be careful with really doesn't like people fussing over them. You have to back off and give this person space."

People's individual dietary requirements were identified and were being met. Nutritional assessments were carried out and care plans and risk assessments included details about people's dietary needs. These included information on cultural and religious dietary requirements, dietitian's recommendations, personal likes and dislikes and the consistency at which food should be served, for example, identifying if someone needed to have their food pureed due to chewing or swallowing problems. We spoke to the cook who told us they were informed of individual preferences by the team leaders and we saw this information was available in the kitchen for staff to refer to. The cook said if there was a particular meal several people did not like, then the catering team would meet to discuss changes to the menu.

People were offered a choice with regards to what they wanted to eat and where. There was a large pictorial menu board with food options for the day. There were at least two choices of main meal, side dishes and dessert. We observed each person being asked what their meal choices were prior to lunch being served. During the meal we saw staff supported people with their meals where needed, chatted with them and the atmosphere was relaxed. We saw staff reacting to people's needs immediately. One person was not happy with the food choice and a staff member offered to change it. Another person started coughing while eating and a staff member immediately attended to the person to check them and to offer gentle help. Daily records of people's food and fluid intake were maintained and if there were any concerns identified with people's nutritional status, they were referred to the GP for input.

People's healthcare needs were monitored and they received input from healthcare professionals when required. Healthcare professionals confirmed people were referred to them for treatment in a timely way. They said staff listened to them and implemented any changes in people's care and treatment that they requested. Comments from healthcare professionals included, "This is a well-run home and staff are on hand and are helpful" and "It's a lovely place and they look after people beautifully." Records were maintained of people's food and fluid intake and also of any observations carried out by staff, for example, monthly blood pressure and weight monitoring. Staff told us if someone was exhibiting unusual behaviour, for example, increased confusion, they would look for possible causes, for example, checking if the person had a urine infection, so they could inform the GP. Care files included a record of input people had received from healthcare professionals and these included the optician, chiropodist, GP, community psychiatric nurse, diabetic care nurse specialist and psychiatrist. The service also received input from the rapid response team who attended for non-emergency situations and to give advice, for example, in the event of someone developing a high temperature. This provided additional support to the service and avoided unnecessary admissions to hospital.

Good

Is the service caring?

Our findings

People were happy with the care they received. Comments included, “Everything is okay” “I am happy enough here…..The staff provide everything I want. I get up about nine and like to be in bed about eight o'clock.” “I like to read.” “It's wonderful. No one has it better than this. Not even the Queen” and “It's okay. I like a good lie-in. I stay in bed a little extra in the mornings. I'm very content here. I am [age] and I don't want to be bothered with much.” One person told us people living at the service cared for each other and said about someone who lacked capacity, “We all love [person] and take them for walks and make sure [person] has the paper.” Relatives were happy with the care staff showed and comments included, “The girls are lovely” and “It is like one big family. “A professional said, “This is a really nice home. The staff are kind with the residents and people are always content here.”

The service was caring and staff treated people with compassion, kindness, dignity and respect. We asked staff about how they maintained people’s privacy and dignity. Comments included, “We work hard here to provide people with what they need, to do things as they like them” and “You can use a towel when giving people a wash, so they are covered. We always close their door.” People had been assessed prior to coming to the service, to identify their needs and wishes. The care plans for personal care included people’s preferences for what they liked to be called, the gender of staff they wished to provide their personal care and how they wanted their privacy and dignity to be respected. Staff were able to describe how they protected people's dignity when carrying out personal care, ensuring doors were always closed and people were not left uncovered or exposed. The majority of bedrooms were single occupancy. Three were double occupancy and people had agreed to share, with agreements being appropriately signed to this effect. Screens were available should people need to be provided with care in these rooms, so privacy and dignity could be maintained. We saw that most people's doors were closed and had a notice on reminding staff to knock. Some people's rooms were personalised, others were not and this depended on the person's own choice.

At 8am on the first day of inspection we saw eight people were up and dressed. Some were eating breakfast and others had already finished. Staff told us people were supported to get up at times that suited them. There was a note on the front of the daily monitoring file which stated “in no circumstances should people be woken up to be dressed. They should be left to sleep and staff allocation should be altered accordingly.” This demonstrated that care was to be led by each person’s wishes. We spoke to one person who told us, “I am always up really early. I like to get up early. The earlier the better for me.” It was clear people had been offered a choice about getting up and getting washed and dressed, and when and where they had breakfast. People could choose from a variety of cereals, porridge and/or toast. The cook explained that people could also have cooked breakfasts if they wished. People got up at varying times and all the people we spoke with confirmed that they were able to get up and go to bed at times that suited them. The activities coordinator asked people their preferences for lunch and we saw this was recorded, so their wishes could be met. At lunchtime we observed food being served in the dining room or in the lounge. Staff explained some people preferred to eat on their own in a quieter area. Some people chose to eat later on rather than at the mealtime, or to eat in a different room and their wishes were respected.

Staff took the time to tell people what they intended to do before they did it. For example, a member of staff said, “Can I take this table away” and waited for agreement before moving it. Staff supported people to transfer from wheelchairs to recliner chairs and we observed they did this carefully and safely, speaking to the person in a respectful manner as they were helping them. One person who was blind seemed anxious and often wanted to go to the toilet. Staff gently supported the person to walk to the toilet on a number of occasions during the inspection. Staff were able to reassure people who were agitated, for example, one person was annoyed because they didn't know why they were there or whether they were wearing their own clothes. They were calmed and distracted a little by a staff member speaking with them in their own language, establishing communication as a means of providing reassurance. The atmosphere in the service was friendly and we observed good relationships between people and staff. Staff gently joked with people who then responded with a smile and seemed relaxed and comfortable.

People did not have to wait long for their needs to be met. For example, we saw one person asking for a piece of toast

Good

Is the service caring?

and a cup of tea, which was served to them promptly. Another person was not sure where to sit during lunch and they were quickly attended and supported in making a decision.

Good

Is the service responsive?

Our findings

People confirmed staff responded to their needs. One person said, “The care here is very good. No complaints. You have to go with the flow somewhat. The food is very good.I prefer to stay in my room. The staff come quite a bit to see I’m alright and I do really prefer it, being on my own. I feel I can keep some independence.” Relatives also expressed satisfaction about the responsiveness of the service, with comments including, “The staff keep us well informed of what's going on and how [relative] is. There was a review last week we were involved with that.” “[Relative] is well looked after. Always seems bright; the home call us and tell us what's going on if there any changes to medication for example. If there is any problem they always help.” “We've never needed to make a complaint. They've always dealt with anything I've taken up very very quickly. For example when [relative’s] glasses were broken they were fixed very quickly and we had a phone call about the optician.” “[Relative] seems comfortable and reasonably happy. We would soon know if [relative] wasn't. There is very good communication.”

People received care that was personalised and responded to their needs. The pre-admission assessment information was used to formulate care plans that described each person’s needs and the support and care required to meet them. Care records were up to date and had been reviewed each month. People and their representatives had been involved with the care records and had signed to agree to them. Although care plans consisted of detailed information about people, some of the goals were set in a way that reflected what staff had to do rather than what people would like to achieve. We discussed this with the provider and the registered manager and they said they would review the records so they reflected the person-centred care we saw people were receiving. Daily records identified any changes in people’s condition or needs, so staff could respond to these and adapt the care and support they provided to meet them. Checks and support given were recorded, for example, night checks and if someone needed assistance to turn in bed, so staff knew how people had been and the help and support they had received. Care records also reflected people’s religious and cultural needs so people’s care was provided to meet these, for example, showering, prayer times, communication and dietary needs.

People were encouraged and supported to maintain relationships with their families and communication with people’s relatives was a priority at the service. Visitors were welcomed throughout the day and the service also facilitated other means of communication, for example arranging Skype calls, so people could maintain meaningful contact with family. Where it was possible, families had taken people out to celebrations, for example, a family wedding, to keep them involved with family life. The care records included a relative’s communication record with evidence of ongoing communication between staff and people’s representatives so they were kept up to date with any changes or significant events, for example, healthcare appointments and being informed about emergency hospital admissions.

There was a varied daily activities programme displayed in the lounge area. We saw some people were reading books, others looking at the newspaper and another person had a quiz book. One person was supported to listen to music on an electronic tablet. The activities coordinator explained every morning they ensured people had the aids they needed to help with communication, for example, glasses and hearing aids. During the mornings a variety of music was played for people to listen to and an exercise session was held. The activities coordinator was able to engage the majority of people in this activity and get them moving and stretching. A quiz was held later in the morning and everyone was actively encouraged to take part. This was followed by song singing and almost everyone got involved and people seemed content and were enjoying themselves.

The activities coordinator showed us plans to develop a structured activity programme tailored to people at various levels of comprehension. This scheme was based on dementia research and incorporated different activities to meet each person’s level of ability. The activities coordinator told us, “It is not just about likes, it’s about capabilities and state of mind. Thinking about what can be done to stimulate people in that moment.” They were a member of the National Association of Providers of Activities (NAPA), which provided training and information around the organising of meaningful activities programmes. They explained the activities programme was set out for each week covering music, exercises, baking, and arts and crafts and this was adapted to meet the needs of people at the time of the activity. We saw examples of the art and craft work carried out by people living in the

Good

Is the service responsive?

service. For example, a piece of artwork using poppies had been produced around the time of Remembrance Day. Activities were provided in the mornings and the need to increase afternoon activities had already been identified as an area for improvement. Each corridor was quite distinctive with different wall paintings and clear directions which helped people find their way around the service.

Information about outings was available and the activities coordinator told us about people who could be accompanied to the local shops and library. Local groups such as the Brownies and the Women's Institute visited periodically and provided entertainments and a local group of hand bell ringers attended twice a year. There was a comprehensive calendar of events for the year, which included religious services, monthly events and annual events. This reflected the cultural and religious diversity of people in the service and included events such as Hindu, Jewish, Muslim and Christian religious celebrations, Saints Days, The Queens' Birthday and Halloween. Care plans contained information on personal interests, hobbies, wishes and activities and outings were discussed at the monthly residents meetings, so activities could be planned with input from people and taking into account their interests and abilities.

People were encouraged to raise any concerns they might have so action could be taken to address them. Copies of an easy read version of the complaints procedure were displayed in the service. This stated clearly how quickly the provider would deal with verbal complaints (3 days), written complaints (28 days) and informed people about external agencies they could approach if they were not satisfied with the response they received. We saw complaints had been investigated and addressed and a satisfactory outcome reached. There was a complaints book for people living at the service kept in the lounge area. This was a useful way of recording informal concerns and what had been done to resolve them. For example, a person had been disturbed by someone who had wandered into their room and this had been resolved by providing a lock so the person could lock their door if they wished. Monthly Residents Meetings were held and people were encouraged to voice any concerns or complaints they might have. The complaints procedure was read and discussed at each meeting, so people were kept informed of how to raise any concerns and were encouraged to do so.

Good

Is the service well-led?

Our findings

Staff and relatives were complimentary about the management of the service. Comments included, "I like working here. The staff are a good team. The management are good and the new manager is very helpful." "I have enjoyed working here. I have been here a long time. People are treated well and the management is good" and "This is a well-run home."

There were good systems put in place to ensure people's care was recorded and reviewed. Pre-admission documents and assessments were designed to gather comprehensive information on people coming to live at the service and to build a good picture of personal needs and health requirements. A full review of care records was carried out annually and more often if required with people and those with power of attorney or who were advocates, so their views could be listened to and incorporated.

People and their families were encouraged to get involved in discussions about the service so their views were sought. Monthly meetings were held for people and a schedule of dates of meetings throughout the year was clearly displayed on the noticeboard, so people knew ahead when the meetings were and could attend. Separate meetings were held for relatives and advocates and minutes of both meetings were recorded, with any actions to be carried out so these were identified and could be addressed. For example, relatives had requested information about communication and the nominated individual had arranged for an experienced member of staff from one of their other services, who had received training from the Alzheimer's Society, to speak about 'effective communication in end of life care for people with dementia.' Staff meetings were also held monthly and minutes were taken, which were typed up so staff who had not been able to attend the meeting could read them and sign to confirm they had done so. Any points were incorporated into an action plan, which was marked off as items were completed. Examples of action points were for staff to read and sign policies and to attend training refresher courses. This showed people, relatives and staff had the opportunity to voice their opinions and points raised were acted upon.

Annual satisfaction surveys were carried out for people and these were in a pictorial, easy read format to assist with people's understanding. Annual surveys for relatives were also carried out. The results of both were reviewed to bring together the outcomes and action any points made, for example, a request for more privacy when visiting prompted the provider to identify areas within the service that could afford privacy during visits. Annual staff surveys were carried out and again, any action taken was recorded.

There were systems in place for monitoring the quality of the service provided, so action could be taken to address any areas for improvement. An annual environmental audit and action plan identified work planned and completed and this included new carpets in several areas, bedroom doors personalised with items people remembered, bedrooms being personalised and families were involved with this work. Audits of several aspects of the service were carried out every one or two months and these included medicine records and stocks, care records, infection control and notifications to the Care Quality Commission.

Maintenance and catering records were audited every three months and the registered manager also carried out daily spot checks. The dispensing chemist carried out an annual medicines audit and any action points were recorded and addressed. Policies and procedures were reviewed annually so the information was kept up to date in line with current guidance. Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.

The provider was a member of the Registered Nursing Home Association and the National Association of Providers of Activities (NAPA). They had also attended the launch of the Hillingdon Dementia Action Alliance. They used information provided by such bodies to inform good practice in the service, for example, the painting of corridor rails orange, in line with dementia research and making them easily identifiable to people. The service read and followed good practice guidance, for example, Dignity In Care – Becoming a Champion, a publication from the Department of Health. The nominated individual said they would be incorporating questions around dignity into the annual surveys and also at meetings to make maintaining people's dignity meaningful and get a picture of people's understanding and wishes. They showed us the Alzheimer's Society dementia friendly physical environments checklist, which they were following when making changes to the service, examples of which were providing clear, bold

Good

Is the service well-led?

signage and effective lighting around the service. This showed the service used good practice guidance and research when planning changes and improvements to the service being provided to people.