St Martins Care Limited

Park View 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?	Requires Improvement

Overall summary

The unannounced inspection took place on 29 July 2015. We last inspected Park View Care Home on 19 November 2014 when we found the service was meeting the regulations that we inspected.

Park View Care Home provides residential care for up to 65 people, some of whom are living with dementia. At the time of our inspection there were 60 people living at the service, but one person was in hospital.

The service had a new manager in post who had not yet applied to become the 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.

People received their correct medicines from staff. The management team ensured that medicines were managed safely and effectively.

People told us they felt safe living at the service. Staff were aware of their personal responsibilities to report any incidents of potential or actual abuse to the manager.

Summary of findings

Emergency procedures were monitored and staff knew what to do in response. Accidents and incidents were recorded and monitored to identify any trends.

The premises was clean, tidy and well maintained and suitably designed for people's needs.

Staff working at the service were able to meet people's needs, we confirmed this through viewing records and from our own observations. We found staff were suitably trained. They received induction, regular supervision and appraisal from the management team. There was appropriate recruitment procedures in place to check that people were suitable to work with vulnerable adults.

People were happy with the food and refreshments available to them and said they had a good selection of home cooked foods.

CQC Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. In England, the local authority authorises applications to deprive people of their liberty. MCA assessments and 'best interests' decisions had been made where there were doubts about a person's capacity to make decisions. Applications to the local authority had been made where a DoLS was required.

People told us that the staff team were very caring. Staff spoke with people in a caring, kind and compassionate manner. They treated people with respect and dignity. People's care needs were identified, and comprehensively assessed, recorded and reviewed by staff with input from people, their families and healthcare professionals.

People made their own choices and there was a range of stimulating activities for them to participate in if they wished. Staff encouraged and supported everyone to maintain family, social and community links. People and their relatives told us they knew how to complain and would be able to if they thought it was necessary.

Audits and quality checks were in place which helped the provider and management team monitor the quality of the service.

Relatives told us they had confidence in the management and staff team and thought the service was well led. Staff told us they felt supported by their colleagues, the manager and deputy manager.

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.

Risks to people had been identified and managed appropriately and medicines were managed safely.

The premises was clean and tidy with generally good levels of maintenance in place.

Staff recognised their safeguarding responsibilities and knew what to do if they had any concerns. All accidents and incidents were recorded and monitored.

Good

Is the service effective?
The service was effective.

There were appropriate induction and training methods in place for staff. Staff were supported by their line manager and management team.

The manager and staff had a good understanding of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005.

People received, or were supported with nutritious meals and were helped to remain hydrated, with special diets being prepared for those that needed them.

Good

Is the service caring?
The service was caring.

People were cared for by the staff in a respectful and dignified manner. We observed staff showing kindness and comfort to people when it was needed.

People and their relatives felt involved in the service and how it operated.

Good

Is the service responsive?
The service was responsive.

People participated in a wide range of activities. They told us they were able to make choices about how their care was delivered.

Care plans were reviewed and updated as people's needs changed.

People and their relatives told us they knew how to complain if they felt it was necessary.

Good

Is the service well-led?
The service was not well-led.

The current manager had not yet completed her application to become registered which is a condition of the providers registration.

Requires Improvement

Summary of findings

Audits and quality checks were completed and monitored by the provider and the management team.

People and relatives were confident in the management team and felt involved in the operation of the service.

Staff felt supported and were positive about team working relationships.

Park View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 July 2015 and was unannounced. The inspection was carried out by two inspectors, a specialist advisor and an expert by experience. A specialist advisor is a person who specialises in a particular area of health and social care, for example medicines, moving and handling or quality assurance. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor concentrated on quality assurance and the expert by experience spoke with people about their experiences of the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service, including the notifications we had received from the provider about incidents and serious injuries. We also contacted the local authority commissioners for the service, the local Healthwatch, visiting healthcare professionals and the clinical commissioning group (CCG). We used their information to support the inspection. On the day of our inspection we spoke with a community nurse who was visiting the service. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 20 people who used the service and 8 relatives or friends. We also spoke with the director of care, deputy manager, the cook and kitchen assistant, the activities coordinator, two senior care staff, eight care staff and one care staff apprentice. We observed how staff interacted with people and looked at a range of care records which included the care records for ten people who used the service, medicine records for twenty people and personnel records for six staff.

We looked at staff rotas, maintenance records, health and safety records and information, quality assurance checks, complaints and compliments and handover information.

During the inspection we asked the provider to send us additional information. For example, a copy of their medicines policy and training matrix. They did this within the agreed timescales.

Good

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I am very safe living here. The staff see to that." Another person told us, "I am very happy here. It's all very nice".

The service had a security system to prevent the entry of uninvited visitors and each person entering the building was asked to sign in and out which ensured the service complied with fire safety measures.

Staff had a good understanding of safeguarding procedures and had received training to support them. They were confident they would report any issues or concerns they had if the need ever arose. Staff had been asked to study the whistleblowing policy as part of their induction. They told us that they understood it and wouldn't hesitate to use it, although we felt two staff members were less confident than others about the process.

Where staff had identified a potential risk to a person, a specific risk assessment had been completed to ensure the person was safe. For example, a risk assessment had been completed for people who liked to go out. The assessments focussed on the potential benefits of taking the risk, such as the person's enjoyment from spending time outdoors, as well as considering the possible hazards. We found from viewing care records people were routinely assessed against a range of potential risks, such as falls, mobility and skin damage. Corresponding care plans had been developed to help staff maintain people's wellbeing.

Fire systems and equipment checks were up to date. There were suitable fire emergency procedures in place, including an up to date fire risk assessment. Staff completed regular fire drills and equipment was suitably maintained. Each person had an evacuation plan to support them to leave the building should an emergency arise. Plans detailed what staff should do following an untoward incident. For example, if a failure of the kitchen equipment occurred. When we spoke with staff, they were confident about where to look for guidance and how to implement it, including where they would buy products if cooking facilities failed and what to do if the dishwasher stopped working.

The premises were clean, tidy and homely throughout and maintained to a good standard, although we did see some areas in the unit for people living with dementia, which were in need of minor decoration, for example the hand rails.

Accidents and incidents had been recorded and reported. There was also an analysis in place to monitor any occurrences. 67 accidents or incidents had been reported from January 2015 to July 2015. They had been dealt with in a timely manner, with appropriate actions being taken. For example, observation charts implemented to monitor people more closely. All issues had been transferred into the falls register and included within the falls audit. Falls were also entered onto the provider's electronic monitoring system for analysis. Learning was discussed with staff through handovers, team meetings and supervision, to ensure improvement was driven through the service.

We observed the medicines rounds in the service and looked at people's medicines records. Medicines were given out in a timely manner, with people reporting no concerns over the receipt of their medicines. Information was available to staff about different medicines, how they interacted with other medicines and also the effects they might have on an individual, such as making people drowsy and making them more at risk of falls. The majority of people had care plans and risk assessments in place for their medicine needs, however, we found two people without paperwork in place. We brought this to the attention of the director of care who said they would address this. We noticed that medicines needing to be given at specific times, for example Alendronic Acid, were listed separately to ensure that staff were aware of the importance of timings.

Medicines records were complete with no gaps and all medicines were available for people to take. Where they were not given, a reason was recorded. Medicines were stored safely and securely in the medicines rooms and temperature checks were taken and monitored to ensure medicines remained effective.

Damaged or unused medicine was recorded and stored separately ready for collection, although they were not stored in tamper proof containers within a locked cupboard as per the National Institute for Health and Care Excellence (NICE) guidelines for medicines in care homes. Staff told us that the facilities for storing medicines was in the process of being moved and this guidance would be taken into account.

The provider had systems in place to ensure all employed staff were suitable to provide care and support to people living at the service. Suitable references had been requested and received. A full employment history had

Good

Is the service safe?

been provided and identity checks had been carried out. The provider had also carried out an enhanced disclosure and barring service (DBS) check. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. We asked staff members about their recruitment process. They confirmed that they were not allowed to start working until checks had been made and confirmation received.

We looked at the training records for three members of staff who held responsibility for the administration of medicines. We found that the provider used a 'medication competency training pack' to support staff to develop their skills and competencies in this area. The training had included understanding best practice, medicines ordering procedures, managing errors, refusals and disposal. It had also included areas such as consent, the management of controlled drugs and "as required" medicines. "As required" medicines are those given only when needed, such as for pain relief. Training had included supervised practical sessions that involved medicines rounds in the service and reflective practice afterwards by the member of staff.

We looked at the staffing levels at the service. One member of care staff told us, "We need more staff across the board. We deal with a lot of hoists and stand-aids, which means we take two staff off the floor at the same time. We looked at the staff rota and staffing levels for a six month period before our inspection and for the month after our inspection. We found that the manager used a dependency tool to plan staffing levels based on the needs of people who lived at the service. We were told the future rota's could change if dependency levels increased. Night shifts were consistently staffed by six care staff and day shifts fluctuated between seven and ten depending on occupancy and levels of need. Staff levels corresponded with the recorded levels of dependency at the time.

Kitchen staffing levels had been inconsistent due to staff sickness. We asked the deputy manager about this. He said, "Yes we have had some issues with keeping staffing levels up in the kitchen but we managed these on a daily basis, so that the service wasn't affected. We can move staff from our other homes at short notice so that meal times aren't affected by unexpected illness." The director of care told us, "We have a core team of mobile staff that we call a 'commissioning team.' They can be deployed at short notice across any of our homes. They are multi-skilled staff and they help ensure we provide continuity of care and safe working environments." One person told us that there had been times when they felt the service had been short staffed. During the inspection, we found people were attended to swiftly and call bells were answered immediately. Staff appeared unhurried and had time to sit and talk with people and people's needs were being met. We discussed staffing with the deputy manager who assured us that this topic was regularly discussed at team meetings and at meetings with people using the service.

Staff told us that, where possible, they tended to work on the same floor of the service, which they said was good for maintaining consistency with people. A member of care staff said, "This way of working is good because you get to know people better. We as carer's can influence the rota, so if someone wants experience in a different part of the home the manager's sort that out for us."

Good

Is the service effective?

Our findings

People told us the service was effective, that the service was spacious and the food was good. One person said, "I come and go as I like. There is a lovely garden and I am often out there."

We spoke with a member of staff about their induction and they said it had been centred around the people who lived at the service, including being introduced personally to them. We were also told about their initial training, which included a varied and practical plan of training, with tests and scenarios to work through. They told us it had been very good and they felt supported throughout by the staff and the management team.

We spent time looking at the training records of six staff in detail and the training plan for the service. We spoke with the director and the deputy manager about staff training. All staff had been trained in areas important to the safety and welfare of people, including first aid, medicines awareness, infection control, food hygiene and equality and inclusion. One member of care staff said, "The practical fire training is excellent, it really makes you open your eyes. We have well-rehearsed fire planning and we all know how to move people to safe zones, if we have a real emergency."

The manager used a training matrix to ensure staff remained up to date with their mandatory training and to alert them when staff training was in need of being refreshed. From looking at this document 31 staff had achieved an NVQ Level two or three and nine more were taking similar qualifications. The director of care told us that she was promoting the Care Certificate across the service with all staff. Staff had specialist module workbooks to help them work towards certification in a structured way. Each workbook included a set of questions that allowed staff to demonstrate their knowledge of a particular subject, such as the legislation relevant to Deprivation of Liberty Safeguards (DoLS) and the warning signs and symptoms of dementia. In all areas of training we found evidence that staff were required to demonstrate their skills and knowledge through a question and answer session that used scenarios with a manager or through the use of a written test paper.

From looking at staff supervision and appraisal records we saw that there was a culture of encouraging training and professional development in the service. For example, each member of staff had a personal development plan through which they had been supported to 'up skill' their training and specialist knowledge. We asked the deputy manager about this. He told us that training was a priority for the management team in terms of ensuring staff were competent and well skilled. He said, "We hold organised training events where staff are invited to take part in important instruction sessions such as nutrition and hydration, end of life care and DoLS.

Staff had all received an appraisal in the year prior to our inspection and most staff had received a supervision session every two months. In some cases these were difficult to follow as they had not been signed by a manager or dated. We asked the deputy manager about the support given to staff. He said, "Staff are encouraged to take the lead in their supervisions so that we know how they feel about their own performance and development. So, they can write their own supervision notes and talk to [managers] about how they would like to be supported to develop." Each supervision included a general update for all staff and was followed by a personalised agenda, based on the individual's performance and development. We noticed a consistent approach to ensuring staff reached a minimum standard of work quality and were encouraged to take on extra training and development. Managers had used positive comments to encourage staff, such as, "[Staff member] is very organised at all times" and "[Staff member] lacked confidence but is developing well and is very competent."

We asked staff about their awareness of DoLS and the Mental Capacity Act 2005. Staff we spoke with were positive about this and were able to tell us how they put their knowledge into practice. For instance, a senior care worker said, "I'm a dementia champion for the home. I was supported by the managers to take the dementia friends training and we brought it into the home. It's a very interesting programme and people have benefited from it – we have open days where dementia specialists come in to talk to staff, people and relatives." The service had made applications and eight DoLS authorisations were in place, which meant that staff understood their legal obligations in this area and had followed correct procedures. Best interest decisions had been made and we saw evidence of this on people's records.

One person felt that the meals served at the service were repetitive. We did not find this when we scrutinised menus

Good

Is the service effective?

from previous days and weeks but passed this observation on to the deputy manager. One person told us, "The food here could not be better." Another said, "The food is smashing". Relatives confirmed this and one said, "The food is like home-cooked". We witnessed the lunch time experience at the service in three different areas; two of the inspection team observed the dining room experience and the third member of the team observed how people received meals in their bedrooms or other areas. People were encouraged to socialise with their friends and staff used techniques to help them with this, such as holding their hand and walking with them from the lounge to the dining room and asking them about the person they were going to sit next to. We heard one staff member say, "Wonder what [person's name] has been up to today."

On the day of our inspection, the gas had failed in the kitchen and so there was a short delay to the lunch service and the menu board was blank. Staff told "This is not a normal occurrence; we are usually all very organised." Staff dealt with this well and explained to everyone why there was a delay. People were kept calm and free from anxiety because staff used the situation to turn the regular lunch into a treat, by telling people they were getting lunch from the fish and chip shop. People were very pleased with this and were happy to wait as a result. Staff had excellent distraction techniques with a person who became anxious at the wait. They read a book with them and found their favourite tankard to have a drink out of. This level of personal knowledge was demonstrated by all staff in the dining room, who knew where people liked to sit and how much they were likely to drink. In another dining room people were encouraged to sing along to the music while they waited.

People were offered juice when they sat down and staff ensured that people had enough to drink during their meal. A member of care staff said, "Quite a few people are prone to urinary tract infections and so we sit them down a few minutes before lunch to encourage them to drink enough fluids." The rapport of staff with people was very positive and conducive to a relaxing and enjoyable lunch. For example, staff noticed that one person was struggling to eat. They were able to encourage this person to eat more of their lunch by sitting with them and reassuring them. In all cases staffed asked the person first if they wanted help before offering it, such as saying to someone, "Shall I cut that up for you? It'll be much easier to eat that way."

We visited the kitchen and found it to be clean and tidy, the cook checking we had followed food hygiene procedures before we entered. Kitchen and care staff were aware of the dietary needs of individuals in their care. We saw lists of people who were on special diets, including those on softened diets and those who were diabetics. We discussed the nutritional needs of people with the cook and felt that they were fully aware of people's individual needs and tastes. People at risk of malnutrition were monitored and referrals made, if appropriate.

People were supported to maintain their healthcare needs. One relative told us staff supported their family member to attend health appointments. People's care records confirmed they had regular input from a range of health professionals including, GPs, district nurses and podiatrists.

The garden area was well tended and in regular use by people at the service. We were told by one person who we walked with in the garden area, that it had recently been 'revamped' The area was fairly flat and accessible to everyone, including those in wheelchairs and with other mobility issues. There was good seating areas and solar powered lighting which would come on automatically. One person said, "It's lovely and peaceful out here, I love to sit out." We also noticed that a canopy had been installed to provide people with shade. We were told that there were plans to have some raised plant and flower beds added to the garden area which would be tended by people living at the service.

Bedrooms had been personalised to individual tastes, including the use of reminiscence pictures, and furniture. The director of care told us more work was underway for people living with dementia, including more sensory items in the garden, better signage and new coloured toilet seats.

Good

Is the service caring?

Our findings

Comments from people included, “I cannot praise everyone at Park View enough and would recommend this to anyone needing excellent care”; “The staff are lovely, so caring” and “Very kind and considerate.”

Comments from relatives included, “When I visit [person’s name], the staff are excellent and kind not only to [person’s name] but to myself. The staff make me feel very welcome and reassure me that my [person’s name] is well cared for”; “The care and kindness shown to our [person’s name] has been absolutely outstanding, very friendly and welcoming staff. Management team are excellent and all staff are very helpful and approachable, nothing seems to be a problem”; “I would not hesitate to recommend this care home, I found Park View to be by far the best with very pleasant staff and a nice homely atmosphere. There are regular meetings for friends and relatives with an opportunity to raise any issues you have. The entertainment provided at the home is discussed and staff put a lot of effort into this” and “This place is like a 5 star hotel. It is spot on. It is lovely and clean and there are no bad smells. Even the garden is lovely”.

Comments from relatives whose family member had passed away included, “After going into the home they were treated with care, kindness and dignity, [person’s name] joined in the wonderful activities which the home arranged and went on trips to tea dances and meals out. If [person’s name] wanted quiet time to themselves they would watch television and knit. [person’s name] always said they were treated like a queen and was glad such a caring home was available.”

People were encouraged to be involved with activities of daily living. For example, one person told us she had completed some work in the laundry and helped with gardening. Another person confirmed that he delivered the daily newspapers to others and enjoyed doing that. One staff member told us that sometimes people liked to fold up napkins or help to tidy their rooms. We noticed a ‘dignity for August’ information sheet displayed on the notice board which stated that domestics and laundry staff would be encouraging people to help if they wanted. All of this meant that people were involved and encouraged to remain independent.

Each member of staff had their own individual manner of speaking with people and they responded well to this. For instance, people responded warmly to a member of staff who addressed them as ‘ladies and gentlemen’ at lunch and other people responded well when they were addressed as ‘darling’. Staff knew each person by name and were able to attend to their individual needs. For example, staff knew that one person liked their hair combed before sitting down for lunch and the person was clearly delighted that staff had remembered and offered to do this for them before they went to sit down for the meal.

People’s spiritual needs were supported through the provision of a Catholic mass held once a month and a weekly Church of England communion service.

Information was available to staff on the diverse food needs of people from various cultures, for example people requiring kosher, halal or afro Caribbean food types. We asked one staff member about this information and they said, “That information is not needed at the moment, but we would use it if someone came to live here with particular requirements.”

Staff had the time to spend with people when they wanted to talk, take part in an activity or just to sit and reflect. We regularly saw people sitting, chatting with staff in the many comfy chairs around the service.

We observed care staff hoisting people during the inspection and noted this was done safely, correctly and with compassion and understanding of maintaining the person’s dignity. Staff took time to reassure people and we saw that this worked well, with people relaxed and not concerned about the transfer.

Notice boards and tables in the reception area, and throughout the service had a vast amount of information on them to keep people and their relatives or visitors up to date. For example, there was information on meetings, events, and dementia, with a monthly newsletter publishing more of the same. One relative told us, “The manager keeps people up to date, but if you want to know anything, you just have to ask.” We noticed that the service subscribed to a nostalgic daily news, called ‘The Daily Sparkle’. This provided details of events that occurred some years ago and had articles about ‘the way things used to be’. We spoke with one of the activities coordinators about this and they told us it was proving to be very popular with people at the service.

Good

Is the service caring?

Information about advocacy services was available but at the time of the inspection no one living at the service was using an advocate. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Good

Is the service responsive?

Our findings

People told us the service was responsive to their needs. One person told us, "The staff are friendly. You only have to ask and they get it". Another person told us, "There is lots to do if you want to join in."

People told us they were involved in discussions about how they were supported and cared for by staff. One person said, "They [staff] ask me every day how I am and how they can help me." Another person said. "The staff are great. They do things I want them to and don't interfere at other times."

Relatives were included in their family member's care. One relative said, "We are fully involved in what happens and I have been involved with meetings about [person's name] care."

Care records were personalised to individual needs and appropriate levels of care and support had been put in place. Care records were reviewed with the person, their relatives and also relevant health care professionals, including medicine reviews with the relevant GP. Staff were able to describe each person's needs when we asked them. For example, one person enjoyed going out with relatives and another enjoyed watching a particular television programme. Staff were able to explain one person's preference's on how personal care was carried out. They were able to tell us how they ensured people remained as safely independent as they could. The director of care told us that there was a programme of continuous improvement to ensure that people's care remained person centred.

Staff had produced a person centred one page profile of people at the service. This was to give a snapshot of the person to staff involved in their care. It would also be used as a reminiscence aid to the person, as the profile included their picture and what they liked to do in the morning, afternoon and evening. For example, one person liked an afternoon nap and at tea time liked to help dry dishes.

Strategies were in place to support staff with behaviour that might have challenged the service. For example, one person had triggers listed which would make them anxious and staff had also recorded what interventions should be followed to manage any situations that may have arisen. Displayed in the staff room was details of a 'formulation meeting' for one person living at the service. The meeting was set to take place with the local behaviour support team and asked staff for their views before the meeting to best support the person in question. This meant people could be more effectively supported when their psychological/ emotional needs increased.

People told us there were three activities coordinators who completed a range of activities and events with them. To celebrate Father's Day, eight people were taken to St James' Park, Newcastle for a day's outing which we were told they thoroughly enjoyed. A wide range of activities were available to people living at the service, including, cooking, hairdressing, chair exercises, sing-a-longs and knit and natter groups.

Coffee mornings, wine sessions and regular visiting entertainers was also organised and we noticed from an advertisement in the reception area that an entertainer was due to visit that coming weekend. We also noticed that it was going to be 'tell a joke' day on the 16th August and chocolate pecan pie day on the 20th August.

People who were living with dementia had a particular event put on that had been tailored to them. It was called 'dementia puppets'. Staff told us that everyone who participated had a great time. One person at the service was blind and staff told us they blew bubbles for them as this stimulated their senses and they enjoyed this activity.

One of the activities coordinators told us they had 'food work outs' for the people to participate in. These sessions involved people cutting up vegetables which would be used for meals. She explained that sometimes it was quite energetic to do this type of activity and people really enjoyed it. One person remembered doing this and said it reminded them of living at home.

To ensure that people were involved in the local community, staff told us that a local community centre came along to the service once per month to play bingo with people living there. We also saw photographs of children from local schools who were regular visitors to the service. The photographs did not show the faces of the children, but some showed them participating in gardening activities and potting plants to give to people for them to cultivate.

People had choice in what they wanted to do. For example, one person came into the ground floor lounge and wanted to get into the garden, although the door was locked. We said we would get the deputy manager to open the door

Good

Is the service responsive?

but the person said, “Oh, I know him! He’s a lovely chap, don’t worry, I’ll get the keys from him.” Another person confirmed they chose what they wanted to do and told us, “I never go out on my own and I don’t want to”.

One person showed us around the garden and in particular some strawberry plants that they had planted. They also told us that solar lighting lit the service up at night. They said, “I am glad my daughter chose this place for me. It is great. Fantastic.”

All of the people we spoke with knew how to complain and said they would speak with management or staff if they needed to. One person felt there was no need to complain and said, “It could not be better. It is so sociable - it is spot on - superb.” Between January and July 2015 there had been eight written and six verbal complaints recorded, which had been all satisfactorily handled in a timely way. The provider had a complaints policy which was displayed thorough the service, although we noted that there was no date on this document. We mentioned this to the director of care and she said she would look into it.

People were supported when they attended appointments. Staff told us this was a normal occurrence when people moved between services, or went to hospital for example. One staff member said, “People don’t like going on their own, so either a family member goes with them or we do.” This showed that staff cared about the feelings of the people they supported and helped them during any transition between health services.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was a manager employed at the service. The location has a condition of registration that it must have a registered manager. We were told the new manager had applied for her DBS check but had not yet completed an application to register with the Care Quality Commission. Although the service was well led, this condition limits the rating in this section to requires improvement.

The manager was on annual leave during the inspection but we were supported by the director of care and the deputy manager. We had spoken with the manager prior to the inspection about unrelated matters and she had been helpful and passionate about the people and staff at the service.

There was evidence of a good team spirit between staff on all three floors of the service during our inspection. For example, we heard staff asking colleagues if they needed help with particular tasks and during lunch we observed staff supporting each other effectively.

In all cases staff told us that they had positive working relationships with each other and the management team. A member of care staff said, "The managers are with us on the floor at the drop of a hat if we need them. We have a good relationship with the two managers' and the director; we always have the opportunity to approach them in confidence if we need anything." Another member of care staff wanted to talk to us about the recent promotion of a senior member of care staff to a deputy manager. They said, "We have an absolutely great relationship. He's [deputy manager] really proved himself. It was a very good move to promote someone who we all knew and respected." Another member of staff said, "The director is also very visible; she is often here walking around talking to people."

The staff room, which was based on the lower ground floor, had snack and cold drinks machines. One member of staff said, "We are lucky, the homes I have been in don't have these." There was a notice board displaying various policies, including bullying and harassment, data protection, receiving gifts and confidentiality which had been placed there for staff to read.

One of the activities coordinators told us that the manager and staff supported the residents' fund by participating in various fundraising events. For example, Red Nose Day, where the staff were sponsored to ride a static bike at the service. She told us that half of the money raised went to the 'residents' fund' and the other half to the 'Red Nose' charity.

We were informed that the service has an account on Twitter (social media) and they use that to help keep in touch and promote the service to others.

Quality assurance systems and audits were in place to assess and monitor the quality of service that people received, together with systems to identify where action should be taken. These included regular in-house audits, conducted by the manager on a weekly or monthly basis, and regular visits by the director of care to monitor the service for the provider. Where issues had been identified, for example, care plans were identified as requiring a more person centred approach, this had been actioned within a 72 hour timeframe. We were confident that issues or concerns would be identified through the robust monitoring measures the service had in place.

Regular meetings were held with people living at the service. Minutes were available that showed a range of discussions had taken place, including those involving activities, food and availability of towels and facecloths at the service. We asked one person if there was a problem with towels or facecloths now and they said, "I am not aware of any problems with them." People confirmed the meetings were productive and allowed them a chance to speak out if they needed to. We noted that regular relatives' meetings included topics around monitoring visits, changes to the service and expenses.

Staff meetings were held regularly and discussions were wide ranging, including care issues. This meant mechanisms were in place to give staff the opportunity to contribute to the running of the service. In addition, as care issues were discussed this meant that any key risks were communicated to staff about people who used the service and care provision was enhanced.

The director of care showed us the results of the survey completed by people living at the service from October 2013 to October 2014 which was based on 19 responses. They told us that the survey was undertaken on an on-going basis and the next results would be compiled in

Requires Improvement

Is the service well-led?

October 2015 from the questionnaires completed during October 2014 to October 2015. The overall view of people ranged between very good to excellent and there were no negative themes identified.

The provider had sent out surveys to professionals and these had been completed by six doctors and nurses and there were no negative themes, although one person had written that the service sometimes could benefit from more staff. We discussed this comment with the director of care who confirmed that the service was staffed in accordance with people's levels of dependency.

As we walked around the service one staff member had left fluid and observation charts in one of the lounge areas. When we spoke with senior staff about this, they assured us this should not have happened and went off to remove the information immediately.

During the inspection we confirmed that the provider had sent us notifications which were legally required. Notifications are changes, events or incidents that the provider is legally obliged to send us without delay.