Ourris Residential Homes Limited

Anastasia Lodge Care Home

Inspection report

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Ratings

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

Overall summary

We inspected the service on 15 October 2015. The inspection was unannounced. At our previous inspection in May 2014 the service was meeting the regulations we looked at.

Anastasia Lodge Care Home provides residential accommodation for up to 29 people, the majority of whom originally come from Greece. On the day of our inspection 28 people were using the service. The home covers three floors. There are two lounges and one dining room situated on the ground floor and 27 bedrooms over all three floors. There is a lift for access to the first and second floor.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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 that we spoke with were positive about the service that they received and about the staff who supported them. People told use that they were treated with warmth and kindness. Staff were aware of people's individual needs and how they were to meet those needs. People were encouraged to build and retain their independent living skills. Relatives, friends and care professionals told us they felt people were safe in the home. There were systems and processes in place to protect people from the risk of harm. These included robust staff recruitment, staff training and risk assessments that considered the individual potential risks for each person using the service.

Medicines were administered safely and staff had received appropriate training. However, some concerns were raised in relation to record keeping of medicines.

We found the premises to be clean and tidy. There was a record of inspections and maintenance checks that had been carried out. The service had an infection control policy and staff had a good understanding on how to follow this effectively.

People told us that the food was good at the home. The chef was aware of any special diets people required either as a result of medical need or a cultural preference. People and relatives were positive about the food.

People received personalised care that was responsive to their individual needs. A one page preference list was available in each person's room and care plans were person-centred with details specific to each person and their needs.

Staff had the appropriate knowledge and skills to carry out their role effectively. All staff received regular supervision and had the opportunity to discuss strengths, their performance and training needs. Staff were positive about working at the home and with the registered manager.

All staff had received training in the Mental Capacity Act 2005 and were able to demonstrate a good understanding on how to obtain consent from people and were able to provide examples. They understood the need to respect a person's choice and decision if they had the capacity to do so.

We saw evidence that the home had applied for Deprivation of Liberty Safeguards (DoLS) where appropriate. DoLS are required to be in place to ensure that where an individual is being deprived of their liberty that this is done in the least restrictive way and reviewed regularly to ensure that it continues to be in the best interest of the individual to whom it applies.

There was an activity co-ordinator in post who we met on the day of the inspection. The home held resident's and relatives meetings where a variety of topics were discussed and people were encouraged to express their views about the service and make suggestions for any potential improvements.

People using the service, their relatives, friends and staff were positive about the registered manager, the operations director and the owners of the service. The service had an open, transparent and family orientated culture where people were encouraged to have their say and staff were supported to improve their practice.

At this inspection there was one breach of Regulation 12(2)(g) which was in relation to proper and safe management of medicines. Please refer to the "Safe" section of this report for details. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement 

The service was not always safe. We saw appropriate systems in place in relation to the administration of medicines. However some concerns were noted regarding the recording processes of medicines.

People who used the service told us they were safe in the home. Relatives, friends and care professionals we spoke with said that people living at the home were safe.

Staff were aware of the different types of abuse and what actions they would need to take to protect people from abuse. Individual risks to people were identified and managed effectively to enable people's safety and to support and protect people's freedom.

Staffing levels were determined by level of need assessments. Recruitment processes were robust and included background checks, reference verification, criminal record checks as well as looking at the experience and skills of potential staff.

Is the service effective?

Good 

The service was effective. All staff had completed relevant training to enable them to carry out their role effectively. Supervisions were carried out on a regular basis and staff felt supported by their peers and senior management.

People's nutrition was monitored. People were offered some choice of meal but there was no evidence that people were involved in the planning of the menus.

People were supported and enabled to make their own choices and decisions. Staff and the registered manager were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and how it should be applied.

People had access to health and social care professionals, when required, to ensure they received appropriate care and treatment.

Is the service caring?

Good 

The service was caring. People told us that they were treated with warmth and kindness. Staff were aware of people's individual needs and how they were to meet those needs.

Throughout the inspection staff were observed talking with people in calm and friendly tones, treating them as unique individuals and demonstrating a compassionate nature.

Summary of findings

Staff showed they had a good knowledge of people's characters and personalities and conversations did not always revolve around care orientated tasks but included much more in relation to the individual, their emotional needs, likes and dislikes.

Is the service responsive?

Good

The service was responsive. Care plans were person-centred, detailed and specific to each person and their needs and requirements. A one page preference guide for quick reference was located in each person's room. People and their relatives were consulted about the care they received and this was reflected in their care plan.

There was no activity plan on display but an activity co-ordinator was employed by the service. The activity co-ordinator was present on the day of the inspection and some people were engaged in activities.

The home had a complaints procedure on display including a version translated into the Greek language. People, relatives and care professionals were aware of who to speak to if they had concerns. Complaints listened to, were acted upon and steps were taken to resolve and learn from issues raised.

Is the service well-led?

Good

The service was well led. There was confidence in how the home was managed.

There was a clear management structure in place and staff felt supported in their role by the manager and operations director. Staff were aware of the values and aims of the service.

The quality of the service was monitored. The registered manager and operations director carried out regular audits however these did not always highlight issues within the home.

Annual resident and relative surveys were carried out with the most recent in November 2014.

Anastasia Lodge 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 15 October 2015 and was unannounced.

The inspection team comprised of two inspectors, a pharmacist inspector 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 information we had about the provider including notifications and incidents affecting the safety and well-being of people using the service. We also contacted Healthwatch Enfield and the local authority commissioning team for their views about the home. Prior to the inspection we also received a provider information return (PIR) from the service. A PIR 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.

During the visit we spoke with eight people who used the service, three relatives, one friend, five staff members, the registered manager, operations director, a visiting district nurse and community matron. Some people could not tell us what they thought about the home as they were unable to communicate with us verbally therefore we spent time observing interactions between people and the staff who were supporting them.

We looked at the care records of seven people who used the service and checked files and records of six staff members. Other documents we viewed were related to people's care including risk assessments, medicine records, relatives, resident's and staff meeting minutes as well as health and safety documents.

Requires improvement

Is the service safe?

Our findings

Management systems were in place to enable the service to monitor and maintain people's safety especially in relation to medicine management. The manager carried out a monthly medicines audit, and the supplying pharmacy carried out a yearly medicines audit. We looked at the most recent audits. These had identified no issues with medicines.

We noted that more detail was needed for some medicines records. One person was having their medicines administered covertly. The GP had carried out a mental capacity assessment and had documented that this was in their best interests. There was a form that the pharmacist should sign to provide their consent to administer medicines covertly. We noted that the pharmacist had not signed this.

We noted that two people were prescribed a pain patch. The site of the patch needed to be rotated to avoid unnecessary side effects. Staff confirmed they did this but they did not keep a record of the patch site. Some people were prescribed medicines to be given when needed such as pain relief. Staff were able to explain what these medicines were for and how they would know whether someone was in pain. However, this was not recorded in a "when required" protocol or care plan.

Some medicines needed to be given at certain times to be more effective, such as at least thirty minutes before food. Staff were aware of this and told us that these medicines were given at the correct times. However, the exact time these medicines were administered was not recorded on their medicines record. One person was prescribed an anticoagulant. This is a high-risk medicine and we saw that the correct dose was being administered. The person's anticoagulant record book with the date of their most recent blood test result and the dose to be administered was not kept with their medicines record according to good practice.

The maximum and minimum temperature of the medicines fridge was not being recorded. Staff were signing the controlled drugs register using their first names only instead of their full signatures. The provider took immediate action and these improvements to medicines records were made during the inspection.

We highlighted these issues to the registered manager and the operations director who assured us that they would ensure systems were in place to address these issues.

This was breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an effective system to order supplies of medicines and the GP reviewed people's medicines every month to ensure appropriate prescribing when people's needs changed. We looked at medicines supplies and medicines administration records for all of the people at the home. These were clearly completed including allergy information and there were no stock discrepancies providing assurance that people were receiving their medicines regularly and as prescribed. When creams were applied and food supplements administered these were also recorded on people's medicines records.

Four people were prescribed sedating medicines for agitation on a when needed basis. Staff recorded the reason when they administered a dose and we saw that these were not overused or used inappropriately. One of these people had needed doses of their sedating medicine for agitation more frequently and we saw that staff had recognised this and that a referral had been made to the community mental health team to assess whether they needed any changes to their medicines.

Two people required injections which were administered by the district nurse. There was a copy of the district nurse's notes in the home so it was possible to check what had been administered. One person was prescribed insulin. Care staff had received training to administer this, to carry out blood glucose monitoring and interpret the readings. Staff were able to explain what action they would take if the readings were out of range. Medicines and controlled drugs were stored securely and there were no discrepancies when we checked stocks held. We observed medicines being given to some people and the deputy manager who was responsible for medicines took time and care to speak with people and to offer pain relief.

Staff responsible for medicines received yearly medicines refresher training. The home carried out competency assessments of all staff who had responsibilities for managing medicines. These assessments documented that staff were able to manage medicines safely.

Requires improvement

Is the service safe?

People told us that they felt safe living at the home and staff treated them with dignity and respect. One person said when asked whether they liked the home said "well it's my home" and "the nurses are wonderful." Another person told us "this establishment is perfect" and "the staff, the manager, very helpful." Relatives that we spoke to told us "my relative is safe here." Another relative told us that "she believes my relative is safe." We also spoke to a visiting district nurse and community matron and both stated that they felt people were safe in the home and did not have concerns about this. The community matron stated "that this is one of the best residential homes in Enfield."

Staff had undertaken appropriate safeguarding training and certificates confirming this were seen in staff training records. Staff were able to define the meaning of abuse and what action they must take if they felt people at the home were at risk. One staff member told us "we are here to keep the residents safe." Staff told us they would report any concerns to the manager or the senior in charge. Staff understood the term whistleblowing and to whom this must be reported to. Staff knew how to report any such concerns. Staff were also aware that if a concern involved a colleague with whom they worked with, this had to be reported to a senior manager. If management did not pay attention they knew that they could contact the local safeguarding team or the Care Quality Commission (CQC). However, staff we spoke with were confident that the management would take all concerns seriously and act immediately. We also saw that safeguarding formed part of the agenda at staff meetings and at relatives meeting and details could be found on the minutes of these meetings.

Staff, as part of their induction also received equality and diversity training. We spoke to the registered manager and a care staff member who demonstrated a good understanding around equality and diversity by telling us that everyone should be treated equally regardless of their gender, race, sexual orientation, religion. They told us that the service had adapted to the individual needs of the people and would follow the care plan to ensure their needs were met.

People who used the service and relatives told us that staff were responsive to their needs and felt that there were always enough staff in the building. Staffing levels had been determined by assessing people's needs which was reviewed regularly and also by observation. For example, where people required one to one assistance, this had been assessed and special funding arrangements had been put in place with the commissioning authority as and when this was required. Staff also told us that there was always enough staff during a shift and that they work together as a team. This included the registered manager, who supported the team where required, such as supporting people at meal times.

The service had safe and effective systems in place to manage staff recruitment. We looked at six staff recruitment files. They contained the necessary documentation including references, proof of identity, criminal records check, and information about the experience and skills of the individual. Staff members were not offered a position without first completing the necessary checks required in order to protect people from unsuitable staff being employed at the home. This corresponded with the start dates on the staff files.

Risk assessments and care plans reflected the care needs of people using the service. They were reviewed on a monthly basis and then shared with relatives and staff members in order for them to agree and be involved in any noted changes in care needs. Risk assessments on file covered areas such as falls, moving and handling, nutrition, psychological needs, continence and use of bed rails. However, where people required the use of food thickeners, this had not been risk assessed and there was no guidance for staff on what amount of fluid to put with the amount of thickener as per medical advice given. We told the registered manager about this issue and the day after the inspection a risk assessment for choking and specific guidance was put in place for staff giving details on how to use thickening agents for individual people.

Standardised tools were used such as Waterlow, to assess pressure risk and food and fluid charts to monitor people's intake especially for those people where concerns had been noted or there had been sudden reduction in food and fluid intake.

We looked at accident and incident records that had taken place over the last three months for the home. There were details regarding the incident, investigation notes and what action had been taken. This information was then collated into a table format and sent to the Care Homes Assessment Team (CHAT) on a monthly basis in order for them to monitor all falls and any emerging patterns. The

Requires improvement

Is the service safe?

community matron told us that they met with the home on a monthly basis to go over any issues, concerns or referrals that may have been raised to effectively manage people's care.

We looked at maintenance records for the home which included yearly, monthly and weekly fire checks, call bell checks, annual carbon monoxide tests and emergency lighting checks. Other checks also included gas and electrical certificates. The home had undergone an environmental health inspection in July 2015 where they were awarded five stars. Hoists, slings, lift, wheelchairs and assisted baths used to support people were checked regularly.

There was a clear evacuation plan for the home which included details of the person, brief details of their mobility needs during the day and the night and where that person could be located during the day and during the night.

The home was clean and well maintained. No foul odours were noted throughout the inspection. An infection control policy was in place as well as daily and weekly cleaning schedules. Domestic staff demonstrated a good understanding on how to maintain cleanliness and infection control within the home. One domestic staff member was able to tell us about which colour coded equipment to use in particular areas of the home.

Good

Is the service effective?

Our findings

People told us that staff respected their choices and decisions and listened to them at all times. One person told us "We don't want for anything here – they (the staff) are kind and can't do enough – I'm content." Relatives told us that "carers are very attentive" and "my relative is very happy."

We looked at training files for six members of staff. We saw evidence that staff had undertaken induction training before they started working at the service. The induction training covered topics such as job duties, use of call bells, food hygiene, health and safety, and moving and handling. The service had also undertaken the provision of the Care Certificate which replaces the Common Induction Standards. This training covers 15 standards which include topics such as duty of care, equality and diversity, work in a person centred way, communication, privacy and dignity, fluids and nutrition, safeguarding adults and other areas to assist the carer to carry out their role effectively.

Training records showed that staff had received training in moving and handling, first aid, Mental Capacity Act 2005, Deprivation of Liberty Safeguards, medicines and dementia care. Training in medicines was followed by competency tests to assess staff knowledge in safe medicine administration. Training was also provided in particular areas to meet specific needs of people using the service. This included subjects such as diabetes care, blood pressure management, end of life, falls prevention, swallowing difficulties and challenging behaviour.

Anastasia Lodge predominately provides a service to people from the Greek community. Staff working at the service had learnt how to speak the Greek language in order to communicate effectively with the people living at the home.

Records showed that staff were receiving regular supervision and annual appraisals, staff that we spoke with were able confirm this. Staff told us that as part of their supervision they were able to discuss strengths, improvements to be made, concerns and training needs. Supervisions also reviewed the eight factors in dignity which included choice and control, communication, eating and nutrition, pain management, personal hygiene, practical assistance, privacy and social isolation.

The service had policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions about their care and treatment. Senior managers as well as all other staff members demonstrated a good understanding of the MCA and DoLS and the importance of obtaining consent. Staff were aware that when a person lacked capacity to make a specific decision they would inform the registered manager, people's families, staff and others including health professionals. They would then be involved in making a decision in the person's best interest.

The home had applied to the local authority for a Deprivation of Liberty Safeguards (DoLS) authorisation for each person to ensure any restrictions on people's liberty was in their best interest and was reviewed on a regular basis. A log was in place detailing the date authorisation was given and the date that this would need to be reviewed.

Staff were able to give us examples of when a DoLS authorisation would be applicable. They explained that when a person refuses personal care and lacked capacity, but it would be in their best interest to receive the appropriate support, a DoLS application would be made in order for staff to support the person legally and appropriately.

Some people using the service had do not attempt cardio-pulmonary resuscitation (DNACPR) orders on their care plan. DNACPR orders alert staff and other healthcare professionals that if a person's heart stopped they would not want to be resuscitated or any resuscitation would not be in their best interest. DNACPR forms had been completed appropriately with clear evidence of a multi-disciplinary approach being taken in order to reach the decision especially where a person lacked capacity.

People talked about the food at the home and were positive in the comments they made. One person told us "the food is nice and fresh" and another person told us "the food is good, fresh and varied." One person after finishing their lunch was asked if they enjoyed their meal, they told us "I always do, if I could eat the plate I would." Another person told us "the food is excellent" and "the food is good – they always get empty plates from me." Relatives also told us "My relative eats very, very well" and "my relative enjoys the food."

Good

Is the service effective?

A four week menu was on display, although there were no menus available on the dining tables. People were able to choose what they would like to eat in the morning. However, at lunch time people were not shown pictoral menus or visual choice to remind them of what they had chosen or possibly give them the opportunity to change their mind. This could apply to those people living with dementia who may have forgotten the choices that they had made. Four week menus were discussed and planned by the head chef and the operations manager. The operations manager told us that they discussed menu content with people living at the service but this was not recorded and therefore we were unable to confirm whether these conversations had taken place.

One person during lunch time told a carer that they had not enjoyed their meal. The carer immediately offered to make the person a sandwich which they declined. The carer then offered the person more fruit which the person accepted.

Some people required a pureed diet which the kitchen was aware of and provided. However, the ingredients to the meal provided had been pureed together and the meal was unidentifiable as to its content. Snacks including fruit and biscuits and drinks were visible around the home and people had access to these at any time. The registered manager told us that they also catered for people from different cultural backgrounds by providing meals which they enjoyed.

People's weights were monitored on a monthly basis and these were recorded as part of their care plan review. Food and fluid charts were completed for those people where concerns had been identified in relation to poor food and fluid intake.

Referrals had been made where required to speech and language therapists, dietetic services as well as the community matron from the care home assessment team to ensure people's nutritional needs were met. The community matron told us that the home always contacted the team where there were any concerns relating to weight loss or poor intake of food and fluid.

People were supported to maintain good health and had access to healthcare service and received ongoing healthcare support. Care plans detailed records of appointments with health and care professionals. People told us "I'm content, if I'm poorly they (the staff) pay attention and get the GP, but I'm usually well" and "if I'm not well I tell the staff and my daughter as I have bad problems with my feet – my daughter explains to the GP when and how it hurts – there is always a staff member present." One relative told us "(my relative) has an illness and staff are fully aware of this and are on alert for any negative symptoms. The GP and family are aware of this and know that that they will be called by the staff if there is any change in her condition."

People's rooms were personalised with pictures, personal items, photographs, televisions and radios. In each room a preference checklist was visible outlining each individual's specific needs and preferences for carers to be aware of. People had access to the garden and activities such as BBQ's and tea parties. The home had some signage which directed people to the toilet and bathroom, although due to the nature of the building, some areas lack sufficient signage for those people living with dementia.

Good

Is the service caring?

Our findings

People told us that they liked living at Anastasia Lodge and that the staff were kind and caring. People told us "My relative spent a lot of time finding a place where I would be happy – and I am" and "It's a very nice place." Another person told us "They are lovely people here" and "It's very good here, I have no complaints."

Relatives told us "My relative looks happy and smiles a lot. In the summer time she likes nothing better than to watch her grandchildren playing in the back garden, I think she is as content as possible." Staff at the home also told us "We really care for our residents, we try to be happy like a family" and "It's a very good place and we are very close to our residents – this is a happy place."

Visiting health care professionals also told us "the home is welcoming and always smells nice, staff are caring and are interested in the residents" and "everyone is always doing something." The community matron told us that he was invited to the home's 25th anniversary BBQ where he had the opportunity to meet families and friends and spoke to them about the care their relatives received.

We observed positive interactions between staff and people living in the home and saw that people were relaxed with staff and felt confident in approaching them throughout the day. One person, during mealtime, was experiencing some discomfort with their denture. The carer immediately responded by removing the denture, cleaning it and supporting the person to put into position again. The person was immediately relieved and continued with their meal.

People had free movement around the home and could choose where to sit and spend their time. People were also given a choice of where they would like to have their meal. The home has two lounges. One is an 'English' lounge where people who speak English can spend time together and the other is a 'Greek' lounge where people whose first language is Greek can spend their time together.

We saw people being treated with dignity and respect. Care staff provided prompt assistance but also encourage people to build and retain their independent living skills and daily skills. One person had the job of folding napkins for mealtimes on a daily basis. She told us that this is her job and it is something that keeps her mind active. She told us "I love doing it."

During mealtimes we observed staff and people interacting well together, chatting and smiling which created a calm and open atmosphere. We saw staff supporting people with their meal while talking to them. Some of these conversations were in Greek. One staff member was showing photographs to a person explaining who the people in the photographs were by name whilst holding the persons hand.

Care plans provided information about how people should be supported to promote their independence. Each care plan was individualised and reflected people's needs, preferences and wishes. Care plans also provided detail on the signs to look for and how to support people who may become distressed or be in some discomfort. Staff understood that people's diversity was important. Care plans took account of people's diverse needs in terms of their culture, religion and gender to ensure that these needs were respected.

We observed staff respecting people's privacy through knocking on people's bedrooms before entering and by asking about any care needs in a quiet manner. During the inspection a district nurse attended to one person. Staff immediately brought a screen to surround the person and the nurse for the duration of the visit to ensure that the person's privacy and dignity was maintained.

We observed that relatives and friends were able to visit at any time. One visiting friend was offered lunch and was able to sit with the person they were visiting and enjoy lunch together. Relatives told us that they felt involved in care planning and were confident their comments and concerns would be acted upon.

Good

Is the service responsive?

Our findings

People and relatives told us that they were happy with the care that they received and felt comfortable in raising any concerns or issues that they may have with the staff and management of the home. Relatives told us that there is "great communication at the home" and "if we had any issues we would speak to the manager."

The community matron told us that the senior management are approachable, responsive and are in regular contact with the care homes assessment team. He also told us that the operations director encourages open communication with the assessment team.

There was a complaints policy on display in the main entrance. The policy had been translated into Greek and a copy of this was also on display. People's complaints were recorded in a complaints folder with minutes of any meeting that had taken place as a result of the complaint. The outcome and further actions were also recorded. A compliments folder was also available with a record of compliments received.

Care plans reflected people's needs and how they would like to be supported by staff. Relatives confirmed that they were involved in all parts of care planning. Care plans contained evidence that people were able to consent to their care and where this was not possible due to lack of capacity a relative had signed the care plan on their behalf. Care plans were also reviewed on a monthly basis. Relatives and staff were then invited to read through the review, make any other appropriate changes and then sign to acknowledge that they agreed with any updates. Care plans also made note of people's preferences in regard to the gender of who provided their personal care.

Life histories were being completed for each person at the home. This information was part of their care plan and gave staff important information about the person's life, their experiences and interests so that staff had a greater understanding of them as an individual. In addition to this a one page preference checklist was also available in each person's room detailing key information about the individual.

A pre-admission assessment had been completed for all care plans that we checked. On the front of each care plan there was also a one page summary. This included a photo of the person and all vital information that was required if a staff in case of an emergency needed to access this information.

One relative told us that their loved one was very reluctant to stay at the home. The home made arrangements for a relative to stay overnight with their loved one on the first night until they felt safe and begun to trust the staff. The relative told us that the management had "bent over backwards to make sure the person was contentedly settled."

Staff knew what person centred care was and that people's needs were always changing and that they had to be aware of this. Staff also told us that they were key workers for people living at the home. Staff told us that their responsibilities included "getting to know the resident deeply, monthly checks for clothes, their room, beds, curtain's – I am responsible for my resident."

The service employed an activity co-ordinator. During the inspection we observed some activity especially in the 'Greek' lounge. No noted activities took place in the 'English' lounge. This was brought to the attention of the registered manager and operations manager who assured us that activities take place equally around the home. We looked at completed activities log for each person living at the home which gave brief detail about activities that the person had taken part in.

The home offered a regular church service within the home and also offered opportunity for people to attend the local church service. The home had close links with the Greek Orthodox Church from where the priest visited the home on a regular basis.

Good

Is the service well-led?

Our findings

People told us that they knew who the manager was and found her to be approachable and understanding. One person told us "the manager is very helpful" and another person told us "she (manager) is beautiful and is very good." A relative told us "we know the manager and if we have any issues we can speak to her."

Staff were also very positive about the manager, the operations manager and the owners of the home. They told us that they could approach the manager at any time and that they were very supportive. Care professionals we spoke with were positive about the registered manager and management within the home. Staff also told us that the registered manager was very "hands on" and would help the staff around the home especially at meal times where people required support with their meal. We also observed this during the inspection. One staff member told us "I love my boss" and "I feel comfortable here." Another staff member told us "we work as a team here."

There was a clear management structure in place and staff were aware of their roles and responsibilities. The owner of the home was also visible on the day of the inspection and was noted to be involved in the running of the service. Most of the staff we spoke with had worked at the home for a number of years.

We saw that there was clear communication between the staff team and the managers of the service. The service held daily handover sessions when shifts started. A communication book was maintained to record daily information about people living at the home which included any concerns or issues noted throughout the day.

We saw records of regular senior and staff meetings. Senior meetings were held every three to six months. Staff meetings were held every two to three months. The last one was also held in August 2015. Agenda items for senior meetings included medicines, duty of care, supervision, key working, accident and incident reporting, behavioural recording. Staff meetings covered areas such as respecting and involving a resident, consent to care and treatment, care and welfare of residents, meeting nutritional needs, safeguarding and a range of other areas. Staff also confirmed this and told us that they were always given the opportunity to discuss care and any other concerns or issues they may have.

The service had quality assurance systems in place to monitor and review the performance of the service and identify areas where improvement was required. This included health and safety monthly checks, infection control audits, monthly care plan audits and monthly and annual medicines audits. However, these did not always highlight issues within the home. Audit forms were comprehensive but the manager needed to ensure that these were completed robustly.

The service had systems in place to ensure that they obtained people's views about the care provided at the home. Residents meetings were held every three to six months with the last one held on 8 September 2015. The agenda included discussions on topics such as: respecting and involving residents, care and well-being, privacy and dignity, meeting nutritional needs and about the staff. Relatives meetings were held every six to twelve months. The last one was in May 2015 and a variety of topics were discussed including: quality assurance, safeguarding, activities, care plans, training. At this meeting concerns were also raised regarding the structure of the evening shift and how this is managed. We viewed evidence that the senior management listened to the issues and set up a new structure of how the shift should be managed. This was trialled for one week and two weeks later a follow up meeting was held with relatives to obtain feedback in regard to the changes. It was noted that relatives were happy with the new structure and felt it was much more effective.

The service had carried out a satisfaction survey in November 2014. We saw that the results of the survey had been analysed. Results and action taken was fed back to relatives as part of their meeting held in May 2015. Eighteen relatives completed the questionnaire. The feedback received was positive and included comments such as "the staff are always ready to listen", "the residents are treated very well when it comes to meal times", "very hospitable", "the staff take time to listen to all issues raised."

The service had a comprehensive range of policies and procedures necessary for the running of the service including a business continuity plan. This ensured that staff were provided with appropriate guidance and direction. Staff also told us, when asked about how they would manage complaints, that they would always follow policy and procedure.

Good

Is the service well-led?

The service maintained strong links with the community and also works in partnership with other agencies. The home had visits from a group that brings to the home a variety of animals to engage with people using the service through 'animal therapy.' The home maintains a positive relationship with the care home assessment team and meets with them on a monthly basis. The service is working towards achieving the Gold Standards Framework in care. The Gold Standards Framework enables frontline staff to provide gold standards of care for elderly people especially those who are nearing end of life. This is achieved through a training programme set by the Gold Standards Framework Centre.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service was not protecting service users from the risks associated with the unsafe use and management of medicines, Regulations 12(2)(g).