New Century Care (Southampton) Limited

South Haven Lodge 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

Summary of findings

Overall summary

This inspection took place on 30 March and 4 April 2017 and was unannounced. The service provides accommodation for up to 46 people with nursing care needs. There were 42 people living at the service when we visited, some of whom were living with dementia. All areas of the home were accessible via a lift and there were three lounge/dining rooms on ground of the home. There was accessible outdoor space from the ground floor. Bedrooms were a mix between single and shared occupancy.

There was a registered manager at the home. 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.

Risks to individuals were assessed and monitored. Where risks were present, the service put measures in place to reduce the risk of harm to people. Where people's health needs changed, the service involved external professionals to ensure people received assessment and care which was appropriate to meet their needs. People had access to healthcare services as required, which helped to maintain their health and wellbeing.

People's care plans detailed people's preferences around their personal care routines and documented areas in which they remained independent. Care plans were regularly reviewed and people were involved in making choices about how they were cared for. Where people lacked the capacity to make specific decisions, the service had followed the principles of the Mental Capacity Act (2005) to ensure that decisions made were in their best interest and were as least restrictive as possible. Staff understood the need to gain consent before providing care and treated people with dignity and respect.

There were sufficient staff available to meet people's needs. The service had robust recruitment processes, which helped ensure that staff were of appropriate character and experience to provide effective care for people. Staff received appropriate training, induction and supervision to carry out their role and told us they were happy with the support they received from the registered manager. Staff had received training in safeguarding and understood their responsibilities in reporting concerns through the appropriate channels, which helped to keep people safe from abuse. People and their relatives told us that staff were caring, compassionate and understood their needs well. Staff cared for people calmly, this helped to create a homely atmosphere within the service where visitors were welcomed and people felt safe and relaxed.

There were systems in place in safely mange people's medicines to ensure they received them as prescribed. Where some people took medicines for anxiety, staff worked with people and doctors to ensure that people were only administered these medicines when necessary to keep people safe.

People's nutritional needs were assessed to help ensure people received appropriate support. Where people required additional help to eat and drink, staff provided the assistance they required and monitored

their food or fluid intake to ensure they were receiving enough to eat and drink.

The registered manager's quality assurance systems ensured that they had an insight into the daily running of the service. They monitored key areas of staff performance and the wellbeing of people to help ensure that issues or concerns were identified and addressed quickly. The registered manager had a 'home improvement plan', which detailed and tracked improvements identified through auditing and feedback. Formal feedback was used to make improvements to the service. Responses from questionnaires and consultation with people had led to changes, which improved the quality of the environment and the care provided. There was a complaints policy in place and people were aware how and to whom to address their concerns.

There was a clear management structure in place at the service. Staff understood their roles well and told us that the registered manager was supportive and approachable. People and their relatives told us the service was well run and provided good quality care.

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.

Risks to people around the service were assessed and monitored to help ensure people lived in a safe environment.

There were sufficient staff in place. The service followed safe recruitment procedures to ensure suitable staff were employed.

Staff received training in safeguarding and had the knowledge to help keep people safe from abuse.

There were systems in place to manage people's medicines to ensure they received them as prescribed.

Is the service effective?

Good

The service was effective.

Staff had a training, induction and supervision programme, which was appropriate to their role.

People's legal rights and freedoms were protected.

People had access to healthcare services when required.

Peoples were supported to follow a diet in line with their preference and dietary requirements.

The provider had made some adaptations to the environment to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring and compassionate.

Staff treated people with dignity and respected their privacy.

People's decisions around their end of life care were respected

and documented.

Is the service responsive?

Good

The service was responsive.

People's care plans detailed the care people required and how they would like to receive it.

People had a range of activities available to participate in.

The registered manager used feedback to make improvements to the service.

There was a complaints policy in place and people understood how and who to complain too.

Is the service well-led?

Good

The service was well led.

There was a clear management structure in place at the service. Staff were organised and motivated in their roles.

The registered manager had embedded systems in place to monitor the quality and safety of the service.

The registered manager had notified CQC about significant events at the service.

There was a whistleblowing policy in place, which staff were confident in using.

South Haven 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 30 March and 4 April 2017 and was unannounced. The inspection team consisted of an inspector, a specialist advisor, who was a registered nurse 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 previous inspection reports and notifications the provider had sent us. A notification is information about important events, which the service is required to send us by law. We spoke with a relative of person who had experience of using the service, who contacted CQC prior to the inspection.

We spoke with 14 people living at the home or their relatives; We also spoke with the provider's regional manager, the registered manager, the deputy manager, seven nursing or care staff and the activities co-ordinator.

We looked at care plans and associated records for eleven people and records relating to the management of the service. These included: staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records. We observed care and support being delivered in communal areas and used 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.

The service was last inspected in August 2014, where it received an overall rating of good.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe living at South Haven Lodge. One person said, "Very safe, yes." Another person commented, "It's safe and comfortable here". One person's relative reflected, "I could not think of a better place. [My relative] was in hospital before coming here and I was worried about what would happen when they came out. I do not have to worry now; [my relative] is being so well looked after."

People were protected against the risks of potential abuse. All staff received training in safeguarding. This training informed them about how to identify different types of abuse and the action staff were required to take in order to help keep people safe. One member of staff told us, "We all have received safeguarding training. We discuss any issues at shift handover or we can go to seniors, deputy manager or the registered manager if we think there is a problem or somebody is at risk of abuse."

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Risk assessments completed for people included risks around: medicines, pressure injuries, choking, malnutrition, dehydration, falls and mobilising around the home. One person had a risk assessment in place as they were at risk of falling when moving from their bed to chair. The assessment detailed how two staff were required to support the person to manoeuvre using a hoist. Staff also monitored the person's weight to ensure they used appropriate equipment when the person was hoisted. This helped to ensure the person was able to move safely from their bed to a chair. Another person had a risk assessment in place as they were at risk of their neck becoming entangled within the cord from the call bell next to their bed. To reduce the risk, the person had agreed to remove the call bell and staff would check on their wellbeing hourly. Records of staff monitoring confirmed these checks took place in line with the risk assessment. This helped to minimise the risk of choking on the call bell cord whilst ensuring staff monitored the person's health and wellbeing.

When people had accidents, incidents or near misses, these were recorded and monitored to identify any developing trends. The registered manager tracked each incident using a computer system, where staff recorded incidents. From this information, the registered manager collated all the reports monthly to look for patterns and put measures in place to reduce incidents. This information was shared with staff at meetings, who were then able to offer input, suggestions or ask questions about new procedures or changes to people's care plans. In one incident, a person exited the building after a visitor left the front door ajar when leaving the building. The registered manager changed the key code for the door and put a procedure in place where staff would escort all visitors from the building, ensuring the door was securely closed. This minimised the risk that people could exit the building unaccompanied if it was not safe for them to do so.

Occasionally people became upset, anxious or emotional. Where this was a known behaviour, people had care plans in place to ensure their safety and the safety of other people and staff. The registered manager had analysed previous incidents involving people to look for potential causes and strategies staff could employ to help reduce reoccurrence. These detailed the triggers for people's anxieties, the emotional support which people required to comfort them and the level of staff interaction, which was effective in supporting them to remain calm.

People were kept safe from the risk of emergencies in the home. There was a business continuity plan in place. This detailed the steps staff were required to follow in the event of emergencies such as: fires, loss of electrical power or loss of water supply. People also had individual evacuation plans. These detailed the support people would require to leave the building in an emergency and the best way to keep them safe.

Sufficient staff with the right skills and knowledge to meet their individual needs supported people. The registered manager used a dependency tool, which took into account people's needs to assess appropriate staffing levels. The registered manager reviewed this dependency tool monthly, to ensure that staffing allocations reflected people's current needs. Most people or their relatives told us staffing levels were sufficient to meet their needs. One person said, "[There is] always staff available to help you." One relative felt that additional staffing was required on the first floor. We spoke to the registered manager who showed us that people on the first floor had adequate staff available to monitor their health and wellbeing in line with their medical needs or health professional's guidance. The registered manager told us, "We are in a good position with staffing, I'm proud to say that we do not use agency staff." Throughout the inspection, staff attended to people's call bells without undue waits and there were staff in constant presence on both floors of the building.

Safe recruitment procedures ensured that staff with the appropriate experience and character supported people. Staff files included application forms, records of interview and references from previous employment. Staff were subject to a check made with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions by identifying applicants who may be unsuitable to work with vulnerable adults.

Peoples' medicines were managed and administered safely. Suitable arrangements were in place for obtaining, storing, administering and disposing of medicines. The provider's process for the ordering of repeat prescriptions and disposal of unwanted medicines helped ensure that people had an appropriate supply of their medicines. The deputy manager told us they had recently introduced an auditing and checking system that ensured that staff accounted for all medicines in stock at the time of each administration. The deputy checked weekly to ensure that records were correctly completed and stock levels reconciled with expected amounts. These measures helped to ensure that people received their medicines as required.

There were suitable systems in place to ensure people received topical creams and ointments as prescribed. This included body charts to identify how specific creams should be applied and records completed by care staff to confirm their application. Staff dated topical creams when they opened containers to help ensure these were disposed of within manufacturer's guidelines.

Some medicines needed to be stored at specific temperatures to maintain their effectiveness. A refrigerator was available for the storage of medicines in accordance with the manufacturer's instructions. Staff monitored and recorded temperatures for medicine storage areas to ensure that medicines were stored at the appropriate temperatures.

Care plans contained information to assist staff to support people who declined to take their medicines and staff were able to explain what they would do when this happened. For example, one staff member told us, "One person sometimes does not like to take their medicines. We have to respect this. We went back to the pharmacist to confirm we could offer the medicines at a different time in the day, it has been a lot better since we have had the flexibility."

Where people were prescribed medicines on a 'when required' basis for anxiety, people's care plans

provided staff with a structured guide of other interventions they were to try, before using prescribed medicines as a last resort to keep people safe. The registered manager told us, "We try to avoid the use of these medicines unless it is absolutely necessary. We do this by creating the right environment, support and staffing for the individual person." People's records showed that staff had followed the information in people's care plans and the use of these 'when required' medicines was limited to occasions where all other interventions were exhausted. This meant that people were receiving the appropriate amount of medicines to meet their needs.

Good

Is the service effective?

Our findings

People were supported by staff that had training to develop the skills and knowledge they needed to meet people's needs. The training comprised of a combination of classroom based, online training and additional training provided by the local authority. Staff undertook training in; safeguarding, moving and handling, food safety, first aid and life support, Mental Capacity Act (2005), medicines management , dignity, health and safety, infection control and dementia awareness. Many staff were competing additional qualifications in health and social care or training related to their nursing registration. New staff received an induction, which was in line with the Care Certificate. The Care Certificate is a nationally recognised set of competencies staff must meet in their working practice that demonstrate they have the skills and knowledge to work in their role. Staff received regular 'refresher' training to ensure their knowledge and skills were updated. The deputy manager told us that, "We have really made an effort in the past six months to ensure that people's training records are up to date. We regularly talk about it in supervisions or team meetings."

New staff completed an induction programme before working on their own. Staff told us they had met the registered manager, the deputy manager, read people's care plans and worked alongside experienced staff, before they were able to work without direct observation. The deputy manager also carried out competency checks for new staff. These observations whilst staff worked helped the deputy manager to assess and ensure that new staff were competent and confident in their role.

Staff had supervisions (one to one meetings) with their line manager. Staff told us supervisions occurred regularly, enabling them to discuss any training needs or concerns they had. One member of staff told us, "I receive a lot of support from the deputy manager and registered manager; it helps with learning and getting better at my job."

People's legal rights were protected as staff followed the principles of the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. When people lacked the mental capacity to take particular decisions, such as the use of bed rails to protect them from the risk of falling out of bed, the registered manager documented how decisions were made in the person's best interests and who was involved in making specific decisions.

Staff sought verbal consent from people before providing care and support by checking they were ready and willing to receive it. One member of staff told us, "Consent is obtained every time we offer a person care." Another member of staff said, "We have had situations where people are reluctant to take medicines or have a wash, you have to respect this decision at the time and do your best to encourage them in other ways."

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 are called the

Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and if any conditions on authorisations to deprive a person of their liberty were being met. We found staff at South Haven Lodge were following the necessary requirements. The registered manager had applied for DoLS authorisations where necessary and showed us records of when authorisations were due for renewal. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way.

The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were recorded in their care plans and in their rooms if appropriate to do so. Where people had specific dietary requirements, such as soft food diets or thickened fluids, staff were clear about the support people required and the risks associated with them not receiving appropriately prepared food and drinks.

Where people were at risk of malnutrition, staff had assessed the risk using a nationally recognized assessment tool. Once assessed, the appropriate level of care was assigned to people to reduce this risk. With some people, this involved monitoring the amount of food they ate and regularly monitoring their weight. Other people required assistance or encouragement to eat provided by staff during mealtimes. Some people had the use of adapted plates or cutlery, which helped them to eat independently. The registered manager reviewed assessments monthly to track any changes or to raise any concerns if they arose. There were examples where people would progress from assessed high to medium risk after additional support and monitoring of food intake from staff. This meant that the risk of them suffering malnutrition and the associated health implications had reduced because of this input from staff.

Staff prompted people to drink fluids regularly in the communal areas of the service. People who were cared for in their rooms had drinks within reach. Where people were unable to have drinks independently, staff recorded and monitored the amount of fluid people drunk due to the risk of dehydration. One relative we spoke to raised concerns that their family member was not receiving appropriate support to ensure a regular fluid intake. We reviewed the fluid recordings staff took over a two week period and found that although on most occasions recordings were consistent with staff offering regular fluids, there was one occasion where there were no recordings of fluids being offered by staff between 1230 and 1830. However, during this time, staff had supported the person to reposition themselves in bed on two occasions. We brought this to the attention of the registered manager, who showed us how they had noticed this issue and addressed this at a staff meeting in March 2017. They had spoken to staff on shift who confirmed fluids had been offered, but they had not recorded this on the monitoring sheet. We checked the fluid monitoring records of six other people and found that they had been offered regular fluids in accordance to guidance in their care plans.

People's care records showed relevant health and social care professionals were involved with people's care. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. When people's needs changed, the service made referrals to specialist services in order to ensure people were receiving the appropriate care. These included dieticians, occupational therapists, speech and language therapists, district nurses, tissue viability nurses and specialist falls services. For example, one person unexpectedly suffered some falls. The registered manager was unable to ascertain the cause or contributing factors, so made a referral to a 'falls clinic', who specialised in finding potential causes for falls and putting measures in place to minimise future falls. The person was waiting referral at time of inspection. Another person struggled to sit in a chair during mealtimes. The registered manager made a referral to occupational therapy, who then recommended an appropriate chair, which the person now used when eating their meals.

The provider had made some adaptions to the environment to make it suitable for people living with dementia. The provider had made adaptions to the ground floor including painting toilet and bathroom doors contrasting colours. This helped distinguish them from the walls and helped people to navigate round the home. The registered manager had increased lighting levels on the ground floor by changing light bulbs used to make communal areas brighter. The Social Care Institute for Excellence states, 'Effective lighting can help people with dementia see where they want to go and to identify spaces, rooms, equipment and signs. It helps them to see other people's faces and body language, to enjoy recreational activities, to join in everyday routines'. There were also signs, notices and pictures about activities, menu choices or period specific items very clearly displayed around the ground floor. This helped to give people a frame of reference about their upcoming day and helped them engage in conversation with other people and staff about events or items of their interest.

The registered manager told us they had planned adaptations to the first floor to increase lighting, paint doors and walls contrasting colours to aid navigation. They also planned to signpost specific areas with street names from the local area to encourage people to reminisce about their past lives and local area. At present the lighting levels were low, which could make it difficult for people to navigate around the floor.

People had access to an enclosed garden via ramps, which had been adapted for wheelchair access. Some people chose to sit in the garden in their lounge chairs, which had been adapted to allow them to be manoeuvred via wheels fitted to their base. One person told us they would like more access to the garden, but required staff to help them do this. We brought this to the attention of the registered manager who told us they were aware of the person's preference for outside space and coming out of the winter, there would be more of an emphasis on utilising this outside space.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. One person commented, "There are a couple of staff here I know very well, they are brilliant." Another person remarked, "They [staff] are doing an excellent job." A person's family member said, "[My relative] could not be happier now."

People were treated with kindness and compassion in their day-to-day care. Staff engaged with people in a caring manner, speaking to people at eye level in a calm demeanour, giving people time to respond to questions and offering them reassurance through touch such as holding their hand. People responded well to these interactions and appeared comfortable in staff's presence. Staff knew people's individual communication skills, abilities and preferences. Where people were unable to communicate their needs verbally, staff were aware of their preferences or mannerisms, which would indicate their responses to questions or requests. This helped ensure that people were comfortable with staff who understood their needs and preferences.

People's care was not rushed, enabling staff to spend quality time with them. There were many staff within the communal areas of the home, who were able to be attentive and spend time individually with people. People were not rushed if they requested drinks or required assistance with personal care. This contributed to a relaxed and calm atmosphere within the service.

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. Where people became confused, or distressed, staff would spend time with them to offer reassurance and comfort. Staff were patient in their approach and used knowledge about people's likes or life history to distract them away from their anxieties to remain calm and comfortable. This was effective as it enabled people to stay in communal areas during this time with minimum distress to themselves or others.

Staff respected people's dignity and privacy. Staff knocked on people's doors before entering their rooms and supported people discreetly away from communal areas when they required help with their personal care. One room had shared occupancy; staff told us how they would use a privacy screen to protect people's dignity and privacy during personal care if both people were present in the room. People were supported to dress and look after their appearance in a manner which reflected their taste. One person's care plan detailed how they would like to have their hair kept and what style of clothing they preferred. The person could no longer verbally communicate these needs, but their preferences around their appearance were respected and followed by staff. Some people enjoyed spending time in their room. Staff respected their privacy, but sought to offer them choice to spend time in communal areas or join in with activities. One person told us, "I can join in (with activities) if I want to, but I prefer being in my room, they (staff) don't force me to join in."

People's rooms were personalised and adapted to suit their preferences. One person said, "I have been here a few months, I feel settled and have my things around me, I like my room and can have plants on my window sill." One relative told us, "[My relatives] room is very personalised, it has pictures of his family and a

few things they took from home which are important to them."

People were supported to maintain friendships and important relationships. Family members told us staff were friendly and welcoming to visitors. One family member said, "I am always made to feel welcome here, it makes coming a pleasure." Another family member reflected, "The staff always make an effort to say hello or offer a cup of tea. I come here every day and have got to know some of the staff very well." One person's family regularly brought their dog into visit them. They told us that staff made the dog's presence welcome and the person responded positively to seeing their canine companion. Other people we spoke to told us they enjoyed the visits from the dog. Comments included, "I love dogs, so it is brilliant they can bring one in", "It reminds me of my dog", and, "I think it gives everyone a lift."

People and their relatives were given support when making decisions about their preferences for end of life care. Staff had received training in end of life care. This detailed the principles of dignified and compassionate care provided during people's last days. Some people had made advanced decisions about the type of care they wished to receive. These preferences were detailed within their care plans. This helped to ensure that people's final wishes were respected and they had a choice about the care they received.

Good

Is the service responsive?

Our findings

Care plans included information that enabled the staff to monitor the well-being of the person. Where people had specific health conditions such as diabetes, care plans included information for staff about the condition, how the person was affected and signs and symptoms there was a change in the condition. Care plans clearly identified the steps staff needed to take in order to monitor people's conditions, such as weight monitoring, food and fluid monitoring or behavioural monitoring, and detailed the actions staff needed to take in order to help maintain people's health and wellbeing.

People had care plans that clearly explained how they would like to receive their care, treatment and support. Where people required support with their personal care, they were able to make choices and be as independent as possible. Some people were able to carry out some aspects of their personal care independently and care plans reflected this preference. People's preferred routines around washing and bathing were included in their care plans. These included ways staff could encourage people to engage in these activities if they were reluctant. One person's care plan documented how they would like to have a specific routine around their hand and nail care. This preference was reflected in the care they received in this area.

People's needs were reviewed regularly and as required. The registered manager told us about a system the service used to review people's needs called 'resident of the day'. People were assigned a specific day on a reoccurring basis, where all their care plans were reviewed, staff would sit with people to get some feedback about the care provided and any changes the person requested would be documented. Where people's health and wellbeing changed, the service involved external health professionals in reviewing people's needs to ensure people were receiving the correct care for their health conditions.

Handover between staff at the start of each shift ensured that important information was shared, acted upon and recorded to ensure people's wellbeing was monitored. Staff told us that any information where people required changes in their medicines or additional care were discussed at staff handover. Senior staff would co-ordinate resources accordingly to ensure these needs were met. This helped staff provide a flexible and responsive service, which reflected the changing needs of people.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. These included group and individual activities and ranged from, exercises, puzzles, quizzes, reminiscence activities, external entertainers to wellbeing treatments such as massage. The service had converted a bedroom into a permanent hairdresser's salon and had arranged for a hairdresser to visit weekly. People who received care in their bedrooms also had access to activities. The activity co-ordinator had designated specific time to visit people in their bedrooms to offer activities on a one to one basis.

The registered manager sought feedback from people and their relatives to find ways to develop and improve the service. Residents and their relatives were sent questionnaires asking for feedback about different aspects of the service and suggestions for improvement. The areas covered included, standard of

nursing care, standard of staff, cleanliness of environment, facilities in the home and confidence in making a complaint. The registered manager and regional manager used feedback to highlight issues and identify ways in which to improve the service. From the last questionnaires sent to people, feedback suggested that improvements were required with the services laundry facilities. The registered manager was able to show us how changes to the maintenance of the laundry area had led to improvements because of this feedback. Results from the provider's last questionnaire drew very positive feedback about the responsiveness and approachability of the registered manager and staff. The provider also sent out questionnaires asking feedback about menu choices available. Feedback from this information helped to develop a new menu, which was shortly being introduced to the service.

There was a complaints policy in place to deal with concerns appropriately. There was a complaints policy clearly displayed in the entrance to the service on a notice board. The regional manager also told us they were implementing new 'welcome packs' for new and existing people who use the service. These could detail information about the service, including how and whom people can make a complaint too. The registered manager logged all complaints onto a computer system, which was reviewed by the regional manager to help ensure complaints were resolved appropriately. People and their relatives had mixed views about how complaints were dealt with by the service. Positive comments from people and their relatives included, "If there was ever anything wrong, I know the manager would listen", "Whenever I have raised any issues, they [the service] have always listened", and, "I know I can complain if I want to, I would go to the deputy manager who I feel would listen." However, one relative felt that complaints had not always been fully resolved. They told us, "The family have had a few issues around (our relatives) we have spoken to the manager but we don't feel they listen to us." We shared the concerns raised to the registered manager, who acknowledged there had been issues, which they were working towards resolving.

Good

Is the service well-led?

Our findings

The vast majority of people we spoke to felt the service was managed efficiently and the registered manager was very approachable. One person told us, "I have experience of many different care homes, and this is a good one." Another person said, "The manager is a caring type of person and runs this place well." A relative remarked, "The care and administration I rate highly." However, one person's relative felt that improvements in the consistency of staff members approach could improve the service provided. They told us, "95% of the care provided is excellent. There are just little things like consistency which can let it down." A social care professional told us, "The registered manager is innovative and works well with other stakeholders, the home often takes complex clients which other homes refuse."

The registered manager had quality assurance systems in place to monitor the quality and safety of the service. These included a 'weekly manager walk around'. This involved the manager touring the home, speaking to people, observing staff, checking the cleanliness of the common areas and bedrooms and observing people's mealtime experience to ensure they were receiving appropriate support from staff. The registered manager also carried out periodic audits around the service in the areas of, medicines management, infection control, kitchen hygiene and safety, environmental health and safety, audits of people's care records, maintenance audits, audits tracking people's activities, checks around people's nutritional needs and records of observations of staff during their working practice. The registered manager assigned actions for staff to complete to remedy areas which required attention. The registered manager also held daily meetings for clinical and care staff. This enabled them to discuss people's health and medical needs to help ensure their care was appropriately planned and monitored.

The registered manager had a computer based system called a 'Quality Performance Indicator Tool', which collated information about key areas of people's health and wellbeing. This included tracking the services dependency tool, hospital admissions, pressure injuries, medicines errors, falls, complaints, infections, weight monitoring and injuries. They used this information to track any trends, concerns or changes in these areas, which may indicate further issues. This helped give the registered manager a very clear insight into the day to day running of the service and welfare of people using the service. Information gathered from quality assurance systems was used to share information, changes and learning to staff through weekly team meetings, daily handovers and supervisions. This helped ensure that staff shared best practice and understood the key areas of development to improve their practice. In a recent team meeting, the deputy manager had emphasised a drive to continue improvement in staff recordings around monitoring people's fluid intake.

The provider had made links to the other professional bodies to monitor and improve the quality of the service. The registered manager invited the local Clinical Commission Group (CCG) to undertake a quality audit at the service. This audit assessed the quality of the care being provided and highlighted areas for development. The registered manager used information from this and internal audits to formulate a 'home improvement plan'. This was an ongoing action plan that was updated monthly and reviewed by senior managers in the organisation. Areas of improvement made in recent months highlighted by the 'home development plan' included; improvements to the organisation and cleanliness of the laundry, improved

systems to maintain the organisation of the clinical room, improvements to recordings around people's weight monitoring and improvements in the number of staff completing their mandatory training updates in accordance with timescales set out in the providers policy. The registered manager told us, "Improvements are always ongoing, you are never going to get everything perfect, you can't get complacent though and that's why we keep updating [the home development plan]."

The provider also had designated additional support resources to the service to help ensure the monitoring of the quality of care. The regional manager told us, "[the quality support manager] visits weekly to offer support around supervisions, clinical training and mentoring and general clinical guidance, as well as supporting the home around clinical recruitment. The home is also supported by our Health & Safety Manager and our internal compliance team who routinely carry out mock inspections."

There was a clear management structure in place at the home. The registered manager was supported by, a deputy manager and senior staff who supervised the nursing and care staff. Staff understood their roles well and told us that the registered manager was supportive and approachable. The provider's regional manager also regularly visited the service to receive updates about the 'home improvement plan' and offer the registered manager support. People and their relatives told us the service was well run and provided good quality care.

The registered manager was committed to their role and kept updated with latest guidance and legislation through internal provider's managers meetings to share information and learning. The provider's regional manager told us that the provider had implemented training, knowledge and learning programme for registered managers. They said, "These modules build to provide an excellent development program covering all aspects of home and people management and has been shaped with direct involvement of the Home Managers." The registered manager told us that they found the training and support offered by the provider had helped them manage the service more effectively. They had recently attended training to develop their communication skills in potentially difficult or challenging situations. The regional manager told us this training would help ensure the registered manager had the skills to approach complex or sensitive issues at the service in an appropriate manner.

The provider had a whistle-blowing policy in place. This provided staff details of external organisations where they could raise concerns if they felt unable to raise them to management at the service. Staff understood how to use this policy. For example, staff told us they could contact the local authority or the Care Quality Commission (CQC) if they needed to. One member of staff said, "I can always whistleblow if I was not assured that a matter was dealt with properly. I don't think things would ever get to that stage though, management are supportive."

There was an open and transparent culture within the service. Providers are required by law to notify CQC of significant events that occur in care settings. This allows CQC to monitor occurrences and prioritise our regulatory activities. We checked through records and found that the service had met the requirements of this regulation. The service had also displayed previous inspection rating on its website and conspicuously in a communal area as you entered the service.