Hexon Limited

The Willows

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 6 December 2016 and was unannounced. At the last comprehensive inspection in January 2016 the service was rated as Requires Improvement overall. At that time we made requirements relating to the safety of the premises and equipment, and to the failure to submit notifications as required by legislation. When we carried out a focused inspection in June 2016 we found improvements had been made in respect of the safety of the premises and some notifications had been submitted in respect of safeguarding incidents and serious injuries, but we were unable to change the rating at that time.

The home is registered to provide accommodation and care for up to 33 older people, including people who are living with dementia. On the day of the inspection there were 28 people living at the home, including one person who was having respite care. The home is situated in the village of Burton Fleming, close to the town in Bridlington, in the East Riding of Yorkshire and also close to the county of North Yorkshire. The premises has two floors and a passenger lift operates between both levels. The general care unit and the dementia unit are staffed separately.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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 were protected from the risk of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and the registered manager had informed the Commission when DoLS applications had been authorised.

There were recruitment and selection policies in place and these had been followed to ensure that only people considered suitable to work with vulnerable people had been employed. On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs.

Staff told us they received the training they needed to carry out their roles effectively and confirmed that they received induction training when they were new in post. Some staff told us that they were well supported by the registered manager, although other staff said they were happier with the support they received from the deputy manager.

Senior staff had received appropriate training on the administration of medication. We checked medication

systems and saw that medicines were stored, recorded and administered safely.

People who lived at the home and relatives told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home, relatives and staff, and that staff had a good understanding of people's individual care and support needs.

A variety of activities were provided to meet people's individual needs, and people were encouraged to take part. People's family and friends were made welcome at the home.

People told us that they were happy with the food provided and we observed that there was ample choice. We saw that people's nutritional needs had been assessed and individual food and drink requirements were met.

The premises were clean and we did not detect any unpleasant odours. The registered manager was aware of how to use signage, decoration and prompts to assist people in finding their way around the home, and good progress had been made towards making these available.

There were systems in place to seek feedback from people who lived at the home, relatives and staff. People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been investigated and appropriate action had been taken to make any required improvements.

Quality audits undertaken by the registered manager and senior managers were designed to identify that systems at the home were protecting people's safety and well-being.

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.

Improvements to the premises had continued since our last inspection.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had usually been recruited following the home's policies and procedures and there were sufficient numbers of staff employed to ensure people received safe and effective support.

Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge required to carry out their roles effectively.

People's nutritional needs were assessed and we saw that different meals were prepared to meet people's individual dietary requirements. People told us they liked the meals at the home.

People's physical and mental health care needs were met. Health and social care professionals were consulted appropriately and their advice was followed by staff.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by

staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their support needs, their life history and the people who were important to them.

Activities were provided although some people felt these needed to be more structured. Visitors were made welcome at the home.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to. There were opportunities for people who lived at the home to express their views about the service they received.

Is the service well-led?

Good

The service was well-led.

The registered manager had submitted notifications as required by legislation since our last inspection.

There was a registered manager in post, and people told us that the home was well led.

Audits were being carried out to monitor the effectiveness of the service.

There were opportunities for people's relatives, staff and health and social care professionals to give feedback about the quality of the service provided.

The Willows

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 6 December 2016 and was unannounced. The inspection was carried out by one adult social care (ASC) 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 this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the day of the inspection we spoke with five people who lived at the home, three relatives, a health care professional, four members of staff and the registered manager. We looked around communal areas of the home and some bedrooms. We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe living at The Willows. One person said, "Having the [emergency] call button [makes me feel safe]" and "Security good, and access to immediate care via the call button." This view was supported by relatives who we spoke with. One relative told us, "My relative is safe because of the attitude of the staff – they have time for them" and "No problems – I feel [Name] is safe." One relative told us they felt their relative was safe, but added that they felt they should be checked more regularly as they often spent time in their room. We fed this back to the registered manager on the day of the inspection and they assured us that this person was checked regularly and that they would ensure their relatives were made aware of this.

Staff described how they kept people safe. One member of staff told us, "We generally look after them. We remove hazards – some are more vulnerable than others" and "We make sure there are no trip hazards, that medication is right and locked away, and that their health and well-being is as per their care plan." A healthcare professional who we spoke with confirmed they thought people were safe living at The Willows.

Staff told us that they completed training on safeguarding adults from abuse, and that they completed regular refresher training. This was confirmed in the training records we saw. Staff were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse. Staff told us that they would report any concerns to the registered manager and were confident they would be listened to and that appropriate action would be taken. Notifications had been submitted to CQC appropriately in respect of any safeguarding incidents that had occurred at the home.

There was a whistle blowing policy on display in the registered manager's office, and staff told us they would use it if needed. One member of staff said, "I think the manager would act but if not I would go above them."

We checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with vulnerable adults. Documents such as photographs to identify the person's identity had been retained. We saw that there was an interview written assessment and evaluation form in use to measure an applicant's suitability for the post they had applied for. These checks meant that only people considered suitable to work with vulnerable adults were employed at The Willows.

We saw a dependency tool in people's care plans and noted that this information was collated to help identify the overall staffing levels that were needed. These were reviewed on a regular basis. The registered manager told us that the standard staffing levels on day shifts were four care staff from 8.00 am until 8.00 pm, one from 9.00 am until 5.00 pm and one from 8.00 am until 4.00 pm Monday to Friday. This was reduced to five staff throughout the day on Saturdays and Sundays. During the night there were three care staff on duty; one working on each floor plus one 'floating' member of staff. We checked the staff rotas and saw that

staffing levels had been consistently maintained, as most staff absences were covered by permanent staff working additional hours. No agency staff were used. In addition to care staff, there was a cook and a domestic assistant on duty each day. This meant that care staff were able to concentrate on supporting and caring for people who lived at the home.

We noted that there was always a staff presence in communal areas of the home and that people did not have to wait for attention. Staff took their breaks at different times so there was always someone supervising communal areas of the home. Most people who we spoke with told us they thought there were enough staff on duty. One person told us, "If I pull the call button staff are here in two minutes. I never have to wait." One relative told us, "Most of the time [there are enough staff]. I come at different times and feel there are enough staff" although another relative said, "It took ten minutes for someone to let me into the home on Saturday and I sometimes struggle to find staff to let me out." Staff told us they felt there were enough staff on duty, although one staff member told us an extra member of staff on duty overnight would be helpful. A health care professional told us, "I can always find a member of staff when I need one." We concluded that there were sufficient numbers of staff on duty to meet people's assessed needs.

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for moving and handling, choking and aspiration, falls, personal safety and infection control. Risk assessments were reviewed on a regular basis to ensure they remained relevant and up to date. Care plans also included a risk assessment that identified any risks associated with a person's bedroom and how these could be minimised.

Staff told us that they never used physical restraint. We saw that care plans recorded possible behaviours that might challenge the service, and how staff should manage these behaviours to diffuse such situations. One care plan recorded, 'If [Name] shows signs of challenging behaviour, staff should walk away and leave [Name] to calm down before continuing.' The care plan also recorded triggers that might lead to such behaviours.

There was a crisis (contingency) plan in place that included advice for staff on how to deal with emergency situations such as a lift breakdown, the loss of utilities, flood and fire. There was an overall record of people's support needs should staff or the emergency services be required to evacuate the premises. In addition to this, each person had a personal emergency evacuation plan (PEEP) in place. PEEPs record the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many staff would be required to assist.

We observed that medication was appropriately ordered, received, recorded, administered and returned when not used. Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. Medication was stored securely in two medication trolleys. Controlled drugs (CDs) were also stored securely. CDs are medicines that require specific storage and recording arrangements. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication held in the cabinet balanced.

There was a medication fridge available to hold medication that needed to be stored at a low temperature. We saw that the temperature of the medication fridge and the area where medication was stored were checked to ensure that medication was stored at the correct temperature. Medication that needed to be returned to the pharmacy was stored securely and recorded in a returns book. There was no audit trail to ensure that medication prescribed by the person's GP 'mid cycle' was the same as the medication provided by the pharmacy. The registered manager told us they would raise this with the pharmacist used by the

home.

We looked at MAR charts and found that they were clear, complete and accurate. Handwritten entries were signed by two people; this reduced the risk of errors occurring when transcribing information from the label on the medication to the MAR chart. We saw that there were no gaps in recording and there were protocols in place for the administration of 'as and when required' (PRN) medication. Codes used to record the reason medication was not administered were used correctly.

The training records we saw recorded that eight members of staff had completed training on the administration of medication. Medication was audited each month and the deputy manager was responsible for carrying out competency checks with staff who were responsible for the administration of medication to ensure that their practice remained safe.

We checked the accident and incident records in place at the home. Accident forms were completed in respect of each incident. The registered manager completed a monthly audit that recorded the action taken following each fall or accident, and to identify if any trends or patterns were emerging. We noted that one person had been referred to their GP as they had fallen several times in one month, and as a result of this referral, their medication was amended. This showed that accident monitoring was effective.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the fire alarm system, emergency lighting, gas appliances, the electrical installation, mobility equipment and slings, and the passenger lift. Weekly in house checks were taking place on the fire alarm and door closers, and monthly checks were carried out on emergency lighting. A fire drill had taken place on 17 November 2016; records showed that staff responded within 20 seconds. Various audits were carried out each month to check on the safety of equipment, such as beds, head boards, pressure relieving mattresses, bed rails, wheelchairs and water temperatures.

At a comprehensive inspection in January 2016 we made a requirement relating to the safety of the premises and equipment. When we carried out a focused inspection in June 2016 we found improvements had been made to the environment. At this inspection we found the improvements to the safety of the premises and equipment had been sustained.

One person told us they were cold because the radiator in their bedroom was not working and a relative also told us that they had previously complained about radiators in a bedroom not working. This had been a reoccurring problem at The Willows and we were aware that new heating systems had been installed in the home to improve the heating and hot water systems. The maintenance person was at the home during our inspection and they adjusted the heating in the rooms that were cold whilst we were present. We saw evidence that room temperatures were being checked on a regular basis in an effort to alleviate these concerns.

People who lived at the home told us the home was maintained in a clean and hygienic condition. One person told us, "The home is spotlessly clean." Records showed that daily and monthly room checks were carried out by the registered manager to monitor safety and cleanliness. Any shortfalls were recorded on the checklist and there was a record of when remedial action had been taken. Infection control audits were carried each month.

Laundry facilities were clean on the day of the inspection. There were separate rooms for 'dirty' and 'clean' laundry, and mops and buckets were stored in a separate area. We noted that clean laundry had to be carried through the area where mops and buckets were stored. We discussed how this area could be

improved to provide more protection in respect of the prevention and control of infection. The registered manager described how the area could be reconfigured to achieve this and told us they would discuss the improvements required with the registered provider.

The home had achieved a rating of 4 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that some applications submitted to the local authority had been authorised and there was a record of when the applications needed to be resubmitted to renew the DoLS authorisation.

The training record showed that staff had completed training on the MCA. Staff who we spoke with understood the principles of the MCA and confirmed they had completed training on this topic.

People told us that staff asked for consent and that they were consulted about their care. One person told us, "I am fairly able – I am never restricted" although another person said, "I feel I have to go with the system." There were forms in care plans that recorded people's consent to their care plan. We saw that one person had not signed their consent form and the registered manager had recorded, "At the current time this resident lacks the capacity to understand or participate in care planning so this has been done in their best interest." We observed that staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals.

Some care plans we saw included information about the person's power of attorney (POA). A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. All of the relatives who we spoke with told us they had POA for their family member.

Records showed that staff followed an induction programme when they were new in post. The staff personnel records we saw showed that staff had carried out numerous training courses in 2016, including moving and handling, health and safety, fire safety, pressure care, dementia awareness, equality and diversity, safeguarding adults from abuse, MCA / DoLS, end of life care and the control of substances hazardous to health (COSHH). This information was confirmed when we checked the home's training record. The training record also recorded how often staff were expected to carry out this training.

Ten members of staff had completed either Qualifications and Credit Framework (QCF) training or National Vocational Qualification (NVQ) training at Level 2. A further three members of staff had completed this training at both Level 2 and 3, and the registered manager had achieved this award at Level 5. QCF has replaced the NVQ award and is the national occupational standard for people who work in adult social care.

Staff told us they were offered sufficient training opportunities to give them the skills to carry out their roles effectively. A health care professional told us that staff had good knowledge and that they highlighted relevant issues.

Staff told us that they had supervision meetings with the registered manager or a senior staff member and they felt they were well supported.

We saw that care plans included information obtained from reliable sources about people's medical conditions and symptoms, such as dementia, healthy eating, how to avoid dehydration and pressure ulcer prevention. This showed that best practice guidance was shared with staff.

A health care professional told us that staff asked for advice appropriately and then followed that advice. They said, "One person who lives at the home was very depressed. Without prompting, staff told me that they were a lot better when I next visited the home." They added, "They get the GP out when needed. I'm confident they would ring for advice if they had any concerns." We saw that any contact with health care professionals was recorded in the person's care plan, and communications from the NHS were also retained with people's care records so that it was available for staff. People told us that they could see their GP whenever they needed to. One person told us, "I asked for a doctor yesterday and they came very quickly."

People told us that they liked the meals at the home. One person told us, "Food good, good choice" and another said, "Basic – meat and veggies and a sweet. Suits me – I love the gateau." Staff told us that there was a list in the kitchen that recorded people's fortified and specialised diets, and their likes and dislikes. The cook showed us this list in the kitchen. There was also a file that contained information about food allergens, and a copy of the three week menu. The cook told us, "The kitchen is open 24 hours a day. If someone asks for beans on toast at 2.00 am they can have it."

Staff told us that the two choices of main meal were explained to people each morning so that the cook could prepare these meals. There was a menu on display and picture menus were used to explain meals to people with cognitive difficulties.

We saw that people's nutritional requirements were recorded in their care plan. Referrals had been made to dieticians or the speech and language therapy (SALT) team when concerns about nutritional intake had been identified. Staff told us that charts were used to record people's food and fluid intake when this was identified as an area of concern so that their nutritional intake could be monitored. Fluid had been recorded in millilitres although it had not been totalled for the day. This made it difficult to see at a glance if the person had taken sufficient fluids. This was discussed with the registered manager who assured us that this would be addressed with staff.

We observed the serving of lunch in the dining room. We noted that staff created a social atmosphere; Christmas carols were being played in one of the dining rooms and people seemed to enjoy this. Tables were set with tablecloths, napkins, condiments and cutlery and each table had a Christmas decoration. People were offered a glass of sherry and one person accepted, and people were offered a choice of dessert. The meal looked hot and appetising. Staff offered people appropriate support to eat their meals. One person was heard to say, "Food lovely." Another person told us, "The meals are quite nice – no complaints. I don't need assistance and I get enough time to eat."

People told us they could find their way around the home easily. We saw that there was signage to assist people to find toilets, the dining room and the treatment room. Bedroom doors were painted in different colours and some had signs or the person's name displayed to help people identify their own bedroom. New

plain flooring had been fitted in downstairs and some upstairs corridors and walls were painted a pale colour; research shows that people with cognitive difficulties find plain flooring and decoration less distracting and confusing. We discussed with the registered manager that it would be helpful for people to have handrails painted in a contrasting colour so they were easy to identify. The registered manager understood that this would be helpful for people living with dementia and told us that this would be actioned. These prompts helped people who were living with dementia to orientate themselves within the home.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff really cared about them. Their comments included, "Yes [staff care]. You can tell by the way they act and talk", "[I am] well looked after. Foods good, very comfy bed" and "They [staff] are busy but they care." A health care professional told us, "Staff genuinely care" and "Staff are attentive and caring." Comments from relatives included, "I heard my family member being encouraged to eat by staff. I was in the hallway and they didn't know I was there" and "They see to [family member]. I have seen the way they approach everyone. They are doing a good job." Another relative told us that they had recently undergone eye surgery. A care worker had collected them from home and brought them to The Willows to visit their family member, and the registered manager had taken them home. They felt that this demonstrated that staff really cared.

Staff told us they were confident everyone who worked at the home genuinely cared about the people who lived there. We saw positive interactions throughout the day between people who lived at the home and staff. We saw that people were comfortable in the presence of staff, and that staff were attentive, compassionate and patient. We noted that one care worker in particular was very skilled in communicating with people, and we fed this back to the registered manager, who agreed with our observations. Relatives told us they were kept informed about their family member's health and welfare. One person told us, "They phone me if any problems" and another said, "I visit every day so am kept informed."

Staff told us they promoted people's independence. One member of staff said, "One lady wanted to go to the shops so I took her out at the weekend" and another told us, "We let them do things for themselves. We encourage them to walk." Relatives confirmed that staff encouraged people to be as independent as possible and only assisted them with the things they found difficult or could not achieve. We saw this to be the case on the day of the inspection.

People told us that staff shared information with them although one person told us, "Not very often but quite pleasing when they do" and another said, "They are busy so don't talk socially". People told us they did not receive a newsletter and that they were not kept informed about events in the home. However, we saw numerous posters displayed in the home that informed people who lived at the home and visitors about forthcoming events and meetings.

Care plans recorded people's preferred name. We saw that staff respected privacy by knocking on doors and asking if they could enter the room. This was confirmed by people who lived at the home, who told us, "Very good – and they don't boss you about" and "Staff knock on doors." Staff told us that they respected people's privacy when they were assisting them with personal care. One staff member told us, "We cover [people] with a towel and lock doors. We know when people want to be on their own."

We saw that people were dressed and groomed in their chosen style. Men were clean shaven if this was their choice and some women were wearing makeup and jewellery.

One person had been assigned an independent mental capacity advocate (IMCA) as part of the DoLS

application process. Their care plan recorded that the IMCA would visit every six weeks, but also recorded the circumstances when the IMCA should be contacted outside of this timescale.

Discussion with staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. We saw that people had a care plan in place that recorded their religious and cultural needs.

Good

Is the service responsive?

Our findings

The care records we saw included care needs assessments, risk assessments and care plans. We observed that assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included privacy and dignity, personal hygiene, communication, tissue viability, sleeping / resting, behaviour, social interaction, mobility, elimination / continence, medication, death and dying and personal safety. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care, the Malnutrition Universal Screening Tool (MUST) and the Abbey pain scale. When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk.

On admission, each person was asked questions about their preferences for care, such as, 'Do you prefer a bath or a shower? How often do you visit the hairdresser? Do you like the light on during the night? and How many pillows do you like?' A 'Getting to know you' form recorded people's hobbies, favourite TV programmes, significant life events, family details and former occupations. This information helped staff to provide individualised care.

We asked staff how they got to know about people's individual needs and they told us they read care plans and spoke with relatives. A health care professional told us, "Staff treat people as individuals. When you ask them about people, they never get muddled up." They added, "There is good communication between our service and staff." Staff told us they had handover meetings at the beginning of each shift and that they discussed any problems in respect of people who lived at the home. This said this helped them to keep up to date with people's current care needs. Care plans were reviewed on a regular basis and monthly audits were carried out by the registered manager to check that care plans were up to date.

Staff told us that they supported people to make decisions about their day to day lives. Comments included, "We let them choose what to wear and give guidance, ask what dinner they want. I have just ordered scrambled egg on toast for one lady" and "We ask them. We ask if they want to do things or not." Care plans recorded information to advise staff on how to help people make decisions and choices. One person's care plan stated, '[Name] cannot choose from a menu so staff need to explain the two choices available'. Their care plan also recorded, 'Staff to assist [Name] to make day to day decisions by breaking down information and giving them time to process the information. To ask closed questions'. Closed questions allow people to respond with simple 'yes' or 'no' responses, making communication more straight forward for them.

We saw that care plans recorded how staff could detect that people were in pain when they were not verbally able to express this. One person's care plan recorded, "[Name] will grit her teeth and screw her face up if in pain for discomfort. [Name] will sometimes shout out and scream when being repositioned or receiving personal care. This is because [Name] does not like staff intervention and not an indication of pain'. A pain assessment had been completed to support this information.

A relative who we spoke with confirmed they felt there was good communication between themselves and

staff at the home. They said they visited regularly and received up to date information each time they visited. A member of staff told us that they supported people to keep in touch with family, friends and the local community. Comments from staff included, "I bring a newsletter in from my local church for a lady – it used to be her church. We encourage visitors and they can use the telephone any time" and "Phone calls are made. We get cards and post them and write letters, and encourage visits."

Relatives told us that they could visit the home at any time and were made to feel welcome. This was confirmed by the people who lived at the home who we spoke with. One person said, "I get plenty of visitors and they are always asked if they want any tea."

The registered manager told us that senior care staff were responsible for ensuring activities took place. We saw that various activities were taking part throughout the day, and there were numerous posters advertising events to celebrate Christmas. However, a relative told us, "There are not enough activities. They just let [my family member] sit all day." A health care professional told us they saw staff chatting to people, doing quizzes and carrying out nail care, but they felt that more structured activities would be beneficial.

A member of staff told us that there was no activity plan and that they arranged activities on a day to day basis to suit people's needs. They said, "We play snakes and ladders, jigsaws and quizzes. There is no rota – we ask the residents. We have singers coming in – that makes the residents happy." There was a hairdresser at the home on the day of the inspection and we were told she visited the home each week.

We recommend that the availability and type of activities available at the home are re-considered, with attention being given to activities for people living with dementia or who do not wish to join in group activities.

The up to date complaints policy and procedure was not displayed around the home on the day of the inspection. The registered manager explained that this had been removed by a person who lived at the home, and would be replaced that day. They said that, when people were first admitted to the home, they were given a copy of the home's statement of purpose, and this included details of the complaints policy and procedure. There had been two complaints during 2016 and we saw both had been dealt with in line with the home's policy and procedure.

People who lived at the home told us that they felt able to express their concerns, and they told us who they would speak to. One person said, "I would ask to see the manager, but I have no problems" and another person told us, "I would tell any staff but I have no complaints." Staff told us they would pass on any complaints to the registered manager or deputy manager. Relatives told us they would speak to the manager and felt that they were approachable. One relative told us, "I have never had any problems – I cannot complain" and another said, "If I had a problem I would tell staff and I feel if anything needed to be done it would be." However, another relative said, "I can approach all staff but [there is] not always a positive response." This was fed back to the registered manager following our inspection.

A satisfaction survey had been distributed to people who lived at the home during 2016. This had been analysed by the registered manager and a summary of the outcomes had been prepared and was displayed in the home. This showed that people were satisfied with the care provided. A separate survey had been carried out about catering in May 2016. The collated responses showed that 100% of respondents felt there was enough choice at mealtimes. People were asked which meals they liked and disliked, and to suggest foods to be added to the menu.

We saw that meetings were held for people who lived at the home and their relatives. The most recent

meeting took place on 16 November 2016, when activities and entertainment were discussed. People who lived at the home requested that the Fishermen's Choir returned to entertain them, and this was agreed. Previous meetings had been held in June and September 2016. One person told us, "We say if we have any complaints. I haven't any. I have also filled in surveys but all is allright." These meetings gave people an opportunity to express their views, make suggestions and ask questions about care provision.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

At a comprehensive inspection in January 2016 we made a requirement because notifications had not been submitted as required by legislation. When we carried out a focused inspection in June 2016 we found some notifications had been submitted in respect of safeguarding incidents and serious injuries. However notifications had not been submitted in respect of Deprivation of Liberty Safeguards (DoLS) authorisations. This meant that the breach of regulation had not been fully met at that time. We dealt with this breach outside of the inspection process and the registered manager submitted the relevant notifications following the inspection.

At this inspection we found the registered manager had continued to inform CQC of significant events in a timely way by submitting the required 'notifications'. This meant that we were able to check that the correct action had been taken by the registered persons following any accidents or incidents.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to their care and support. We found that these were well kept, easily accessible and stored securely. The judgements from the most recent inspection report were on display in a prominent position.

We observed that the registered manager interacted with people who lived at the home and relatives throughout the day and that these interactions were positive and friendly. It was clear the registered manager knew all of the people who lived at the home well. Although two people told us they did not know who the registered manager was, one person told us, "It is [Name of registered manager] and she is always there to talk to" and another said, "[Name of registered manager] and I could talk to her."

Relatives told us they had completed satisfaction surveys and attended relative meetings. Their opinions varied. Two people felt their comments had not been listened to, but one relative told us, "I have attended one or two meetings and our opinions are acted on." Some staff felt that the registered manager did not always listen to 'staff problems' and said they had more confidence in the deputy manager. One staff member told us, "I have confidence in the deputy manager but not in the [registered] manager. But she has got better." We were aware that the new registered manager had taken over from a long-standing registered manager and that it would take staff some time to get used to a new style of management. However, we fed this information back to the registered manager for their consideration.

The registered manager carried out various quality audits to monitor that the service was being operated safely and to meet people's assessed needs. These included audits of accidents, safety of the premises, care plans, nutrition, medication, kitchen cleanliness, water temperatures, fire safety, complaints and people's weights. We noted that a person's GP was informed if they had repeatedly lost or gained weight, and there

was a record of when their GP had visited them.

The registered manager told us that the home's values were to provide a service that was friendly, a 'home from home' and family atmosphere and to promote a culture of respect and dignity. They added that, for people having respite care, the aim was to return people to their own home. Staff described the culture of the home as "A nice atmosphere – we all get along" and "Pretty good. Staff and residents are great and there is a good atmosphere." Feedback in a professional survey recorded, 'There is a relaxed family environment. Helpful staff. Clients appear happy and looked after'.

Staff meetings were held periodically and staff told us they could ask questions and make suggestions at these meetings. One member of staff said, "I think they [staff meetings] are beneficial." We saw the minutes of the staff meeting held in June 2016. The topics discussed included bed rest, staff breaks, cleaning and night staff duties. Staff had also been issued with a satisfaction survey, and records showed that there had been some negative feedback about activities. As a result, a designated care worker was made responsible for ensuring activities took place each day. On the day of the inspection we saw that this continued to be in operation.

Staff told us that they learnt from incidents that had occurred at the home. One member of staff said, "One resident got let out by a visitor. We had to change the key pad number. Staff learnt from this." This showed that there was learning from incidents that occurred at the home.