Crown Care II LLP

Osborne House

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 26 and 27 April 2016 and was unannounced. At the last comprehensive inspection of this service on 18 and 19 of February 2015 shortfalls were identified in relation to record keeping and auditing. This was a breach of Regulation 17 HSCA (RA) Regulations 2014. Also shortfalls were identified in relation to medicines administration, and we made a recommendation about this. We carried out a focused inspection on 7 August 2015 to follow up on these concerns. We found that practice had improved in both areas but we did not change the rating as to do so required consistent good practice over time. At this comprehensive inspection, improvements in these areas had been maintained.

Osborne House is registered to provide accommodation for up to 74 older people some of whom lived with dementia. There were 51 people living at the service when we inspected. Accommodation is provided over three floors; residential care is provided on the ground floor, nursing care on the first floor and care for people living with dementia on the third floor. The home is set in private secure gardens. There is a car park for visitors. The home is situated in Selby close to local amenities.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were safely handled and risks were well assessed to protect people.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the home. The home had sufficient suitable staff to care for people and staff were safely recruited. The environment of the home was safe for people and monitoring checks were regularly carried out. People were protected by the infection control procedures in the home.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date across a range of relevant areas.

Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and they understood the principles of the MCA and DoLs. People were protected around their mental capacity.

People's nutrition and hydration needs were met. People enjoyed the meals and they were of a good quality. The registered manager was completing some work with a small number of people who lived at the service and visitors about elements of dissatisfaction over the meals. Specialist advice around people's health care was sought and followed.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst

treating them with dignity and respect. Staff had a knowledge and understanding of people's needs and worked together well as a team. Care plans provided detailed information about people's individual needs and preferences. Records and observations provided evidence that people were treated in a way which encouraged them to feel valued and cared about.

People were supported to engage in daily activities they enjoyed and which were in line with their preferences and interests. Staff were responsive to people's wishes and understood people's personal histories and social networks so that they could support them in the way they preferred. Care plans were kept up to date when needs changed, and people were encouraged to take part in drawing up their care plans, their reviews and to give their views which were acted upon.

People told us their complaints were responded to and the results of complaint investigations were clearly recorded. Everyone we spoke with told us that if they had concerns they were always addressed by the registered manager who responded quickly and with courtesy.

The service had an effective quality assurance system in place. Osborne House was well managed, and staff were well supported in their role. The registered manager had a clear understanding of their role. They consulted appropriately with people who lived at the service, people who mattered to them, staff and health care professionals, in order to identify required improvements and put these in place. Records around good governance were clear and accurate and led to planned improvements.

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.

People were protected from the risks of acquiring infection because the service had good infection control policies and procedures and staff acted on these.

Risks to people's safety were assessed and acted on and risk plans included how to maximise freedom.

People were protected by having sufficient staff who were safely recruited and had the skills and experience to offer appropriate care.

People were protected by the way the service handled medicines.

Is the service effective?

Good

The service was effective.

People told us that they were well cared for and that staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide good care.

The service met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA).

Is the service caring?

Good

The service was caring.

Staff were skilled in clear communication and the development of respectful, caring relationships with people. Staff involved people in all decisions.

Staff had respect for people's privacy and dignity.

People received compassionate and appropriate care when they reached the end of their lives.

Is the service responsive?

Good

The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests which supported staff to offer person centred care.

People were supported to live their lives in the way they chose.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place. Leadership was visible and there was a quality assurance system in place so that the registered manager could monitor the service and plan improvements.

Communication between management and staff was regular and informative.

The culture was supportive of people who lived at the home and of staff. People were consulted about their views and their wishes were acted upon.

Osborne House

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.

This inspection took place on 26 and 27 April 2016 and was carried out by two adult social care inspectors. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. We received a Provider Information Return (PIR) from the service. This 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. We used the information on the completed PIR to support our judgements and also gathered information we required during the inspection visit.

During the inspection visit we spoke with five people who lived at the home, four visitors, five members of staff, the registered manager, deputy manager, regional manager and the managing director. After the inspection visit we spoke with one health and social care professional.

We looked at all areas of the home, including people's bedrooms, when they were able to give their permission. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at four care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for three members of staff. We also observed the lunchtime experience and interactions between staff and people living at the home.

Good

Is the service safe?

Our findings

People told us that they felt safe at Osborne House. One person told us, "I feel safe here, much safer than being at home." Another person said, "I feel safe when I am being hoisted." Another person said, "They have talked through with me about the risks about my care and how they are trying to reduce these as much as they can. The large rooms and easy access bathroom make a big difference to my confidence and feeling of safety." Another person told us, "I trust all of the staff and feel happy with them all." One visitor told us, "The place is always so beautifully clean and smells lovely." The visitor went on, "There are always staff on hand if I need help or if I want to ask a question." Another visitor told us, "Staff are around all the time," and "They respond quickly to the bell being rung."

We saw there were safeguarding policies and procedures in place. Staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the home procedure was in relation to safeguarding.

The registered manager had kept CQC informed about safeguarding incidents which had taken place in the service. Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively. The registered manager told us that they had invited the local safeguarding team to a resident meeting to inform people about their role, to talk about safeguarding and to ensure people were aware of how to raise any concerns about safety.

We asked the registered manager how they decided on staffing levels. They told us they calculated this using the numbers and dependency levels of the people living at the home at any time. This meant that there were currently two members of staff on the floor which specialised in care for 11 people who were living with dementia. On the floor which specialised in care for people with predominantly nursing care needs, there was a nurse, four care staff and the deputy manager who was supernumerary but on occasion assisted on whichever floor required support. This was for the current occupancy of 20. On the ground floor which specialised in care for people who required residential care without nursing, there were usually three members of staff on duty for the current occupancy of 19. This meant there were usually 10 members of care staff on duty each day, two of which were nurses. Most staff told us that this was sufficient to care for people according to their plans of care, though one told us that this was not always the case, and that they sometimes felt that people were not getting their breakfast in a timely manner on one of the floors due to completing duties around personal care in the mornings. A concern raised with the local authority from a relative supported this view. From our observations however the staffing levels appeared safe, though at times they may not be sufficient for staff to feel unrushed all of the time.

The home also employed an activities organiser and a number of volunteers to assist with providing social and recreational stimulation. They also employed domestic and maintenance staff to ensure the building was clean, well maintained and safe.

We looked at the recruitment records for three staff which showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) for each member of staff and that three references were obtained before staff began work. DBS checks assist employers in making safer recruitment decisions by checking that prospective care workers are not barred from working with certain groups of people. This meant that the home had taken steps to reduce the risk of employing unsuitable staff.

Care plans identified a person's level of risk and records showed that these were regularly updated to reflect people's changing needs. When they were able to do this, people told us that each area of risk had been discussed and agreed with them and we saw records which confirmed this. Risk assessments were proportionate and included information for staff on how to reduce identified risks while avoiding undue restriction. Staff told us that their approach to risk was responsive to people's changing needs and mental capacity. They told us that the home had an open and positive approach towards managing risk and that management supported and encouraged them to challenge any practice they considered unsafe.

Prior to our inspection visit and during the past number of months from August 2015 there had been a number of safeguarding alerts raised by the home to the local authority around the safe handling of medicines at the home. These covered medicine administration errors and incorrect recording. These concerns had been investigated and most had been completed and closed by the local authority with two alerts under current investigation. The registered manager told us what had been done to reduce the risk of medicine errors happening again. This had included a reduction in the use of agency staff who were less familiar with the dosette system of medicine handling and an improvement in the way medicines were audited. Audits now included a daily spot audit, a check at the end of each shift at handover and the introduction of a new more thorough monthly auditing tool. The audits carried out so far using this method were thorough and any identified errors had been quickly dealt with.

Solid and some liquid medicines were dispensed using a monitored dosing system (MDS). The medicines were delivered in trays of pods arranged for each individual in days of the week and times of day such as morning, afternoon and evening. Each separate pod was sealed with a transparent membrane. The named contents of each pod were printed on the membrane and dated so that staff were able to check the contents against the medication administration record (MAR). MAR charts had a photograph of each person on every page. Also each individual tray of medicines carried a printed photograph of the person. These measures reduced the risk of medicine administration error. The MAR had a photograph of each tablet or liquid contained in each pod so that staff could easily distinguish between the medicines. When medicines were administered, the member of staff responsible opened the pod only when they were with the person who was about to take the medicine. This reduced the risk of cross infection and error. After the medicine was administered the membrane was placed in water which removed the print and protected confidentiality around waste.

Those medicines which were not stored in the MDS and were provided in boxes or bottles were stored in named individual sections of the medicine storage trolleys to reduce the risk of administration errors. All medicines stored in this way were dated on opening and a running stock balance of tablets and fluids was kept so that stocks could be accurately monitored. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, (CDs) which are medicines that require extra checks and special storage arrangements because of their potential for misuse. This meant that people were protected around the management of CDs.

The home had a safe system for returning unused medicines and for the disposal of sharps. Some medicines required refrigeration and these were suitably stored. Records of the fridge temperature and the

temperature of the medicines room were kept to ensure the temperature of these was safe.

On the first floor and second floor of the home we checked the stocks of some boxed medicines against the MAR charts and these were accurate. We also checked a sample of the MDS pod trays and checked these against the MAR charts. These were also accurately recorded with no gaps. We observed part of a medicines round on the ground floor. Medicines were administered safely and signed for immediately following administration. The member of staff we spoke with was knowledgeable about people's medicines and why certain medicines were necessary. Staff with responsibility for administering medicines had received training through e learning and a face to face training session was booked for later in May 2016. Senior staff carried out regular medicine administration competency observations to ensure staff were following safe medicines practice.

The service had a policy and procedure around medicines which took into account the requirements of the Mental Capacity Act (MCA) (2005).

The medicine handling systems in place meant the service had taken steps to ensure that people were as protected as possible around the way they received their medicines.

In the Provider Information Record (PIR) the registered manager stated that the service carried out a number of safety checks and audits to the building, services and grounds. Records confirmed that regular checks took place and that any identified shortfalls were addressed. The environment supported safe movement around the building and there were no obstructions.

We observed that staff wore protective aprons at mealtimes which is good practice and in line with infection prevention and control measures. Staff told us that they had received training in the control of infection during their induction and had received regular updates. They correctly described how to minimise the risk of infection. Staff spoke of the importance of using aprons and gloves and told us that they washed their hands frequently and always between offering care to people. The service had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. Wall mounted sanitising gels were available on each floor of the home. Bathrooms, toilets and people's individual rooms had wall mounted soap dispensers and paper towels in line with current best practice guidelines. The laundry room had a suitable washing machine and dryer. Dirty and clean laundry were kept separate and laundry was stored in colour coded bags to minimise the risk of cross infection.

Good

Is the service effective?

Our findings

People told us that the service supported them with their health care. One person said, "They have done all they can to understand my condition." Another person said, "The staff are gentle and helpful when they move me." One visitor said, "They have been really good with getting the GP and I am confident they would contact a specialist if it was needed." They went on, "They are always careful to ask [my relative] how he prefers to be cared for, and to involve him in everything they do with them." One visitor said, "We have seen [my relative] up about in [their] wheelchair more often which is good." Another person said, "The food is good, and there are snacks between meals, nice cakes and biscuits or whatever you want." Another person said, "I have just eaten a salad for my lunch and it was very good. The tables look lovely." However, some people had contacted the registered manager to raise concerns about the quality or quantity of the food.

Each member of staff had an induction to the service. Staff confirmed that they had received induction before they began their mandatory training. During this time they developed a good understanding of each individual's care needs and the philosophy of the home. Staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met. For example, one member of staff accurately told us about the care a person required including how they should be supported to move, their needs around nutrition and fluids, their medicines, pressure management and how the risks should be managed around their care.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone and only did so when they confident. This was to make sure they understood people's individual needs and how risks were managed.

Staff received a range of training relevant to their role including specially sourced training in areas of care that were specific to the needs of people at the home. The registered manager told us about the training they considered mandatory in the PIR, this included medicine handling training for all staff who had responsibilities in this area. Staff told us about other additional clinical training such as diabetes care, dementia care, pressure ulcer prevention, tissue viability and palliative care. Training was delivered in a variety of ways according to what was most appropriate. This included e- learning and face to face training.

Staff told us that they received regular supervision and appraisal. We saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and to offer the care people needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application process 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.

People's plans of care showed that the principles of the Mental Capacity Act 2005 (MCA) Code of Practice had been used when assessing people's ability to make decisions. The registered manager told us that they were planning to improve this area of care planning to involve a mental capacity element in each individual area of the care plan to support staff to give people the right care.

People's need for advocacy involvement was assessed and recorded. The service had a policy and procedure on the MCA and DoLS to protect people. Staff understood the principles of the MCA and DoLS and were able to tell us about the five main principles, for example that they should approach people with an assumption of capacity, and they should support people to make their own decisions.

People told us they were regularly asked for their consent to care. We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response. Care records showed that people's consent to care and treatment was sought. Care plans contained instructions on how to look for consent when people were not able to give this verbally, for example, through observing body language or facial expressions. People's choices about their care were recorded for staff to follow.

Decisions which needed to be made in a person's best interests were recorded and evidence was provided that this was carried out with a multidisciplinary team approach as the MCA advises. An example of this was a decision about a person being assisted to eat using a syringe rather than a spoon.

The home had links with specialists, for example the diabetic care nurse, tissue viability nurse and the speech and language therapy team (SALT). Advice from these specialists was written into care plans and daily notes confirmed that the advice was being followed. This advice helped staff to offer appropriate and individualised care. We saw that referrals for specialist input had been made promptly in discussion with each person or someone they wished to be involved.

Care plans contained details of how to meet people's clinical care needs. Examples included pressure care, nutrition and fluids, and how to support people to move safely. Risk assessments were in place around clinical care. The service used the malnutrition universal screening tool (MUST) which is a recognised risk assessment tool to determine whether people are at risk of malnutrition. They had scales for use with a hoist, and chair scales which could be used for people were not in a position to bear their own weight. When these were not suitable, a nurse told us that they used the MUST guidance to measure upper arm circumference.

Food, fluid and turning monitoring charts were in place to protect people where necessary. Those we checked were accurately completed with no gaps and reflected the guidance set down in the care plan and risk assessments. Each person who required their fluids to be monitored, had a target fluid intake calculated using a recognised tool. The total fluids a person had taken were calculated at the end of each day to determine whether each person at risk had received sufficient fluids for their health. This provided information for the registered manager to adjust care plans when necessary.

The registered manager told us that they were developing pictorial menus which would be useful for those people who were living with dementia or who had difficulty reading the written menu. The home had achieved a level 5 food hygiene rating which meant that the level of food hygiene had been assessed as very good.

There had been a number of specific complaints raised over previous months by people who lived in the home and relatives about the quantity and variety of food on offer at the home. We examined menus which showed that two choices were available at each meal, though some choices were similar. For example, on Fridays the option was fish and chips or egg and chips. Some people said there was an emphasis on meat and too much spicy food. The registered manager told us that people could order an omelette, cheese and biscuits, a sandwich or a salad if they did not wish to have the options on offer. However for some people this did not feel adequate. The registered manager was planning a resident and relatives meeting on the evening of the inspection visit to gather people's views about the menus and their suggestions about how it could be improved. After the inspection, the registered manager told us that they had listened to what people told them and were going to address individual concerns. This meant entering into an on going dialogue about the quantity and quality of meals with individuals, offering as many choices as possible while also balancing this with the requests of the majority.

The service user guide for the home stated that there were refreshments available between meals, and that people who are able to help themselves to hot drinks and snacks were encouraged to do so in the kitchenettes available on each floor. We observed people using these during our tour of the building.

We observed part of a breakfast meal on the second floor during the second day of inspection where a hot meal was served and appeared of a good quality and quantity. We also observed part of a mealtime on the first day of inspection on the ground floor. Three care workers were supporting people at this time. This meant that staff was nearby people at all times to assist them. The food appeared nutritious, well presented and people were given choices of drinks to have with their meal. Care workers were attentive to people's needs, and sat with them at eye level when they were supporting them with eating. This meant that staff responded to people's needs regarding support whilst eating and drinking.

Care plans contained information about people's food likes and dislikes. Those people we spoke with told us their preferences around food were respected. Allergies in relation to food or drink were also recorded. Specific diets to take account of medical conditions such as diabetes were recorded, and any fortified or prescribed supplements. This meant that people's needs in relation to food and drink were assessed and provided for.

Good

Is the service caring?

Our findings

People told us that the staff were kind and considerate. One person told us, "They are always willing to help." Another person told us, "They have been wonderful about helping both me and my relative come to terms with the move into residential care." "Staff use the right tone of voice. They don't talk down; they treat them as an equal." Another person told us, "it is lovely here, everyone is wanting to help you and cheerful."

However, another person said, "They listen to what I say, but sometimes they don't always do what they agree to. I think they get busy and forget to come back when I need support to turn during the night."

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. We saw that staff encouraged people to express their views and listened to their responses. Those people who were in discomfort were attended to with kindness. Staff reassured people where this was appropriate and showed that they were aware of people's likes and dislikes, those people who were important to them and details of their personal history. For example one member of staff told us about the job a person had done as a younger adult and how this impacted on their current care. Most staff gave the impression that they had plenty of time though some were at times moving about quickly and occasionally asked a question without waiting for the response.

We observed that staff approached people with respect and concern for their dignity. Staff told us that they respected people's right to privacy and dignity and spoke about using a kind tone of voice, listening to people and being sure to support people discreetly and in a way which made them feel comfortable. Care plans contained instructions for staff on each person's needs in relation to emotional support. For example, one plan stated, "Staff are to note [the person's] non- verbal body language and observe for signs of pain." Another plan stated, "[The person] has poor sight and reacts to gentle touch from staff to reassure them when needed."

People were assessed around their need for advocates or Independent Mental Capacity Advocates (IMCAs) so that their voices and wishes could be heard and acted on. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions.

The registered manager had organised for people who needed them to have communication aids so that they could make an informed decision about options open to them. Staff visited people in their own rooms and chatted to them so that they did not feel isolated. We noted that staff visited people who were being nursed in their rooms in this way.

In the PIR the registered manager told us that the service was implementing a new 'resident of the day' initiative. This meant the person would have a review of their care plan, their choices revised around daily living, meals and any activities or interests they wished to be arranged for them. This was to be organised on a rolling programme so that during a month each person had an opportunity to be resident of the day.

People were involved in their care plans, and supported to make choices and decisions about their care.

Evidence for this was provided in care plan documents and daily notes.

Some people had Advance Plans in place which were well documented. (Advance Plans record people's preferences when they near the end of their lives). A local funeral director sometimes visited the home at coffee mornings to discuss advance planning and options for funeral care with people who lived at the home and their relatives. Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place, and where we saw these they were correctly completed and regularly reviewed.

Staff told us about the way people were cared for in their final days. They emphasised the need for close liaison with palliative care professionals, attentive monitoring to ensure people did not suffer pain and how important it was to ensure people had company at their beside. They also spoke about the importance of supporting relatives, the people who lived at the home and each other at that difficult time. Care plans included details of who should be involved when a person reached the end of their life and who had lasting power of attorney.

Good

Is the service responsive?

Our findings

People told us that the service was responsive to their needs. One person told us, "I can't fault the care and the attempts to meet my needs." and "We sat for a long time and wrote my care plan together." One person told us, "The staff are genuinely interested in what I want to do, when I needed some shopping they took me out so that I could choose the things I wanted." People told us they welcomed the resident and visitor meetings. They felt these kept them informed and gave them an opportunity to raise any issues. A visitor said, "We went to residents meeting and we were listened to and things were sorted out." However a small number of people had contacted the local authority to tell them their concerns had not been resolved.

When people had the capacity to do so, they gave us a clear account of the care they had agreed to. They told us that staff had sat and consulted with them while completing their care plans. Some people signed their care plans and we saw that these were regularly reviewed. It was clear from the records that people had been involved either through signing their care plans, or by staff writing records of what the person had told them. Reviews focused on wellbeing and any improvements which could be made to people's care. Relevant specialists were consulted for advice at these reviews. Monthly updates were recorded and these contained useful and relevant details to assist staff to plan responsive care.

People had identified areas of interest, likes, dislikes and preferences within their care plans. People's life histories were recorded with their permission. The registered manager told us in the PIR that they were planning a more comprehensive life history document which could be updated as staff got to know people better. However, plans currently contained information such as previous occupations, hobbies, family and friendships, spiritual needs, preferred clothing and ways to spend time. Where people did not have the mental capacity to give a view, efforts had been made to consult with others who were important to them, advocates or Independent Mental Capacity Advocates (IMCAs). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions.

Specific staff were employed to engage people in one to one or group activities according to their preference. People's preferences around daily activities had been recorded and staff told us that they supported people who chose this to go out on outings, into the garden and to a day centre with support. We observed a group activity during an afternoon. People were laughing and chatting and clearly enjoying this. Visitors were involved in this activity and staff had created a positive, encouraging atmosphere. The service kept an activities log which gave details of what each person had been doing, whether they enjoyed it and plans for further pastimes.

The service had good links with the local community. Work based student experience placements were offered to the local college and schools were invited to give choir performances for people's enjoyment.

On the floor which specialised in care for people living with dementia, the environment had been organised so that people were supported with their needs for stimulation and activity. Along the corridors scarves of different colours and textures were tied around grab rails. Also there were a selection of hats and jewellery for people to try on, handbags and purses for people to take and use. Staff told us that people enjoyed

coming across these objects as they explored the corridors and that they sometimes acted as a point of familiar reference for people. In one of the lounges we saw jigsaws, dolls, soft toys, objects to stimulate reminiscence such as biscuit tins, posters, newspapers and magazines out on display. Local adult Guides had knitted hand muffs, which were studded with a variety of different textured buttons and materials for people to explore. People were freely using and engaging with these objects and they were used as points of discussion by staff.

During a morning observation in the lounge which specialised in caring for people living with dementia, staff encouraged people to chat with them and each other, and they listened to what people had to say, responding to their needs. Several people began a spontaneous singing session, with staff making suggestions and others joining in. All appeared to enjoy this.

In the lounge which specialised in caring for people with predominantly nursing needs we observed staff assisting people with looking through magazine s and supporting two people to watch a film they had chosen. They brought the people refreshments of their choice and placed the people at a distance from the television to allow them to clearly hear and see the film they had chosen.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs.

Staff could tell us about people's care needs and how these had changed. They explained how referrals to health care professionals had been made to ensure care remained appropriate for each person. Records confirmed this.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously. We saw that the service had a complaints procedure and staff told us this was followed. We heard from the local authority that a small number of people had raised concerns in the resident and visitors meeting, mainly in relation to the meals but felt that these were not dealt with in a timely way. We later heard that these concerns were being dealt with as specific rather than systemic concerns and the manager told us they were working with individual people to resolve their complaints. The people we spoke with told us that they were confident that their concerns would be listened to and dealt with courteously. One person told us, "If I had anything to complain about then I would talk about any problem with the manager or with the staff nurse on duty." Another person said, "I have complained about one or two things and management have listened and talked to the staff about it." We saw a record of complaints and the outcomes with timescales to monitor how these were managed. When people made a formal complaint the registered manager wrote acknowledging this and then wrote again to inform the person of the results of their investigation and to check that the person was happy with the outcome.

Good

Is the service well-led?

Our findings

People were positive about the registered manager. One person told us, "I see [them] every week day." Another person told us "I have never had any problems, and [the registered manager] seems very approachable." A visitor told us, "The resident and visitor meeting was interesting and we found things out."

The home had a registered manager in place who was qualified for the role and who had been working as manager for seven months. They were supported in their role by deputy staff, a regional manager and by the managing director. We met both the regional manager and the managing director during our visit. They had come to the home to support the registered manager during the inspection. The registered manager told us that the company's senior management offered good support and encouraged them to discuss issues in a positive way.

The registered manager held regular resident and visitors meetings. These were advertised to people on signs within the home prior to the meeting taking place and agenda items were circulated. Times of meetings varied to allow as many people as possible to attend. Minutes of meetings showed that these were well attended and agreed actions were recorded. Meetings were used as opportunities to listen to people's views and to pass on information, or to have speakers.

The service was a member of the Independent Care Group, (ICG) which provided weekly updates and training opportunities relevant to staff. This showed that the registered manager sought advice and support from external organisations.

The registered manager carried out a range of audits to ensure that the service provided people with safe and good quality care. These included risk areas such a checking bed rails, pressure care, infection control, falls, medicines, accidents, kitchen safety and training. Where shortfalls were identified, an analysis was carried out with actions in place to minimise future risks. Lessons learned and reflections for future learning were recorded for staff discussion in meetings.

People had been surveyed for their views about their care. For example, people had been surveyed about the activities on offer. This had resulted in the home developing a plan and this would be communicated to people through the residents and visitors meeting.

The registered manager carried out a daily walk around the building where they identified any issues, and spoke with people and staff. Accidents and incidents which needed following up were carried out during this time, observations of a meal time and checks on people who were feeling unwell. The registered manager told us that this supported them to be more visible around the home and to pick up on things which needed attention. For example, they had recently noticed that a bathing chair needed to be changed during this walk around.

Staff told us that the registered manager was open and positive with them, and that they felt supported in

their role. They had a daily staff meeting which gave them information and guidance to care for the people on the floor they were working. Full staff meetings also regularly took place, with minutes kept and identified actions recorded. The registered manager told us that they were developing marketing tools, such as improvements to the website and brochures, to improve the quality and clarity of information given to people so that they could made an informed choice about admission.

People we spoke with told us that the registered manager often called on them for a chat and that they were approachable. However, a small number of people had reported to the local authority that the registered manager was not approachable and they had raised a concern about this. The service was dealing with this through residents and visitors meetings and one to one meetings with individuals. A number of staff and people who lived at the service told us that the deputy manager was particularly helpful and "level headed" and that they could go to them for support.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support. The registered manager and staff consistently reflected the culture, values and ethos of the home, which placed the people at the heart of care.

Notifications had been sent to the Care Quality Commission by the service as required.