Barchester Healthcare Homes Limited

Hunters Care Centre

Inspection report

Cherry Tree Lane
Cirencester
Gloucestershire
GL7 5DT
Tel: 01285 653707
Website: www.barchester.com

Date of inspection visit: 19 and 20 August 2015
Date of publication: 27/10/2015

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

Overall summary

Hunters Care Centre is part of the Barchester Healthcare Homes Limited and is situated on the outskirts of Cirencester in Gloucestershire. The home can accommodate up to 97 people who require nursing care. The service also provides care for people who are living with dementia.

The service provided consisted of three separate units. A residential unit called The Lodge, which was home to eight people. A nursing unit arranged over three floors and, a unit for people living with dementia called Memory Lane which was arranged over two floors. At the time of our inspection 77 people were using the service.

This inspection was unannounced and took place on 19 and 20 August 2015.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 safe because the registered manager and staff team understood their role and responsibilities to keep people safe from harm. Staff knew how to raise any concerns regarding people's safety. The provider acted appropriately when concerns were raised. There were enough suitably qualified and experienced staff. However, the feeling amongst some staff was that there wasn't always enough staff and that some shifts were too long. The service used a dependency tool to calculate safe staffing levels. However, the tool had not always been consistently and correctly used. Employment checks were carried out on staff before they started work to assess their suitability to work with vulnerable people.

People were supported to take appropriate risks and promote their independence. Risks were assessed and individual plans put in plans to protect people from harm. People were protected from the risks associated with medicines because the provider had clear systems in place and staff had received the appropriate training.

People were provided with effective care and support. Staff had received the appropriate training to meet people's needs. Staff received individual supervision aimed at improving their skills and abilities in meeting people's needs. The service complied with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to eat and drink and their individual needs, wishes and preferences were catered for. Arrangements were made for people to see their GP and other healthcare professionals when they needed to do so. The environment had been designed to meet people's needs.

People received a service that was caring. They were looked after by care staff who were familiar with their needs and wishes. People were involved in making decisions about how they wanted to be looked after. People had positive relationships with the staff caring for them. Staff treated people with dignity and respect.

People received person centred care and support based upon individual needs assessments and care planning. They were offered a range of activities. People said they enjoyed these activities. However, people said they'd like more trips out. Opportunities for trips tended to be restricted due to lack of space on the minibus. People were encouraged to make their views known and the service responded by making changes.

The service was well led. The registered manager, deputy manager and senior staff were well respected and provided effective leadership. The quality of service people received was monitored on a regular basis and where shortfalls were identified they were acted upon.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safe from harm because staff were aware of their responsibilities and able to report any concerns.

There were enough suitably qualified and experienced staff. However, the feeling amongst some staff was that there wasn't always enough staff and that some shifts were too long. The service used a dependency tool to calculate safe staffing levels. The tool had not been consistently and correctly used and was being reviewed by the management team.

The provider carried out checks on staff before they started work to assess their suitability to work with vulnerable people.

People were kept safe and risks were well managed whilst people were encouraged to be as independent as possible and engage in activities.

Medicines were well managed and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People were cared for by staff who received sufficient training and individual supervision to meet their needs.

The service complied with the Mental Capacity Act 2005 (MCA) and supported people to make choices and decisions.

People were supported to eat and drink, with their individual needs, wishes and preferences provided for.

People's healthcare needs were met and staff worked with health and social care professionals to access relevant services.

The service had been designed to meet the needs of people.

Is the service caring?

Good

The service was caring.

Staff provided the care and support people needed and treated people with dignity and respect.

People were cared for by staff who knew them well and were familiar with their needs.

People were involved in making decisions about how they wanted to be looked after.

People had positive relationships with the staff caring for them.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and met.

Summary of findings

The service provided to people was based upon person centred care plans designed to meet people's needs and take into account people's likes, dislikes, hobbies and interests.

People participated in a range of activities. People said they would like more trips out.

The service listened to people's views and made changes as a result.

Is the service well-led?

Good

The service was well led.

The service was calm, relaxed and person centred.

The registered manager, deputy manager and senior staff were well respected and provided effective leadership.

Quality monitoring systems were in place and used to further improve the service provided.

Hunters Care Centre

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 19 and 20 August 2015 and was unannounced. The inspection was carried out by two adult social care inspectors, one specialist advisor with specialist knowledge of services for people living with dementia 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.

The last full inspection of the service was on 31 January 2014. At that time we found the service was compliant with regulations.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR) before the inspection.

The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

We contacted six health and social care professionals, including community nurses, social workers and commissioners. We asked them for some feedback about the service. We were provided with a range of feedback to assist with our inspection.

Some people were able to talk with us about the service they received. We spoke with 21 people using the service. Not every person was able to express their views verbally. Therefore we carried out a Short Observational Framework for Inspection session (SOFI 2). SOFI 2 is a specific way of observing care to help us understand the experience of people who could not tell us about their life in the home. We also spoke with relatives of eight people using the service.

We spoke with 15 staff, including the deputy manager, nursing staff, care staff, maintenance staff, activities staff and administrative staff.

We looked at the care records of 12 people living at the service, five staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty, recruitment, accidents and incidents, equality and diversity and duty of candour.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I'm perfectly alright. They're all lovely people, very, very kind". Another person said, "I do feel safe, it's the surroundings and the people. The staff are competent and nice. We know the staff are all pretty sensible people". A relative we spoke with said, "Whenever I go away from here I know Mum is safe. I was able to have a holiday recently and I did not have to worry".

People were kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. Staff completed safeguarding training as part of the induction and on-going training programme. They were provided with information regarding what is meant by safeguarding people, what constitutes abuse and what their responsibilities were to keep people safe. Staff told us they would report any concerns they had about a person's safety or welfare to the nurse in charge, the deputy or the registered manager. They knew they could report directly to the local authority, the Care Quality Commission (CQC) or the Police. However, they did not have the contact details. It would be beneficial if this information was displayed in a staff area in case they needed it. Information was however, displayed in the nursing office regarding a whistleblowing help line so staff could report any bad practice. Staff we spoke with knew about 'whistle blowing' to alert management to poor practice.

Three safeguarding alerts had been raised in the 12 months before our inspection. On each of these occasions the provider had taken the appropriate action. This included sharing information with the local authority and the Care Quality Commission (CQC). We had not received any whistleblowing concerns relating to Hunters Care Centre in the 12 months before our inspection.

Risk assessments had been completed for each person in respect of mobility, the likelihood of developing pressure ulcers, falls, malnutrition and dehydration. Where people needed to be assisted to move from one place to another a safe system of work had been devised. This set out the equipment to be used and the number of staff needed to complete the task. Risk assessments were completed where bed rails were in use to ensure these did not pose an increased risk to the person. Where it had been determined that a person was at risk of choking a management plan was in place, healthcare professionals were consulted with and the catering staff were informed.

Personal emergency evacuation plans had been prepared for each person. These set out the level of support the person would need if the building needed evacuation. The plans we saw had been prepared on 10 August 2015 and were kept under continual review. This information was stored in the person's care file and also the 'grab file' kept with fire records at the front of the building. The deputy manager told us the 'grab file' contained important information needed in the event of an emergency. They said this was placed in the lobby area so it could be taken if the building needed to be evacuated.

The maintenance team had a programme of daily, weekly, monthly and three monthly checks to complete. These included fire safety checks, hot and cold water system checks and an assessment of any maintenance required. The fire risk assessment was last updated in June 2015. We saw there were still some action identified on the assessment that had not been completed but the team had planned for these to be done. There was a business continuity plan in place with an identified place of refuge should Hunters Care Centre need to be evacuated.

We received mixed feedback from people using the service regarding whether there were enough staff to meet their needs. People said, "I think that there are enough staff", "I've only got to press a bell in the night and someone would come". Other people said, "Quite often we have to wait a long time for help" and, "They're sometimes short of staff". Relatives we spoke with also gave mixed feedback regarding staffing levels of the service.

During our inspection we saw that depending on the time of day, the minimum number of staff working with the 40 people on the nursing unit and residential unit was two qualified nurses and five care staff.

Staffing numbers on Memory Lane had recently been reduced because of a number of empty beds. There were two qualified nurses, five care staff and one hostess on duty for the day shifts. The primary role of the hostess was to assist people with their drinks and meals. A significant number of people needed support in this area. Two staff said that the expectations of the hostess role in Memory

Good

Is the service safe?

Lane was unrealistic, as one hostess was not enough. Staff said the new staffing levels were not adequate and had impacted upon the care they were able to deliver to people.

Staff we spoke with said, "At the end of a 12 hour shift we are exhausted. If you do three of them in a row, you are fit for nothing by the end of it", "Today I am working with two new care staff and although they are very good, I don't have as much time as I would like to support them, let alone get everything done", "Just because there are a couple of empty beds we have one less member of staff. There is no recognition of how dependent people are". One member of staff said, "I would not let my Mum live here on 'bad days'" and went on to explain that this was related to the staffing numbers and "being too busy to provide good care".

A new dependency assessment tool had recently been introduced; there were however discrepancies in the characteristics used to determine whether a person had high, medium or low care needs. For example a person who needed help to eat their meals and have drinks was rated as medium dependency and a person who received their nutrition via a feeding tube was rated as high dependency. The time involved in providing care and support in these instances differed considerably.

During our inspection we did not see any examples of people's safety being affected by there not being enough staff to meet people's needs. However, the mixed feedback we received regarding staffing levels and the discrepancies noted in the use of the dependency tool, require attention. We discussed this with the deputy manager at the end of our visit and they said they were already reviewing the use and findings of the dependency tool in order to ensure safe staffing levels.

Relevant checks were carried out before staff started work These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check an applicant's police record for any convictions that may prevent them from working with vulnerable people. References were obtained from previous employers. Recruitment procedures were understood and followed by the manager.

There were clear policies and procedures for the safe handling and administration of medicines. These were followed by staff and this meant people using the service were receiving medicines safely. Medicines were securely stored and records of administration were kept. Medicines were re-ordered on a four weekly basis. Most medicines were supplied in a blister-packed dosage system. There were satisfactory stock control measures in place for those medicines supplied in bottles and packets. All medicines were stored safely and at the correct temperatures.

Where people needed to be given their medicines covertly (hidden in food or drink) the appropriate steps had been followed in respect of the Mental Capacity Act. Best interest decisions had been made for the person by healthcare professionals and the correct documentation was in place. Medicine reviews were undertaken by the GP on a six monthly basis. One person said, "I need help with my pills. It is safer that way, I used to get in such a pickle before I came and lived here". Some people were prescribed medicines administered via an adhesive patch applied to their skin. We talked with the lead nurse in Memory Lane regarding the need to ensure patches were not replaced on the same skin site for a specified period of time, in line with the manufactures guidelines.

Staff told us they had access to equipment they needed to prevent and control infection. They said this included protective gloves and aprons. The provider had an infection prevention and control policy. Staff had received training in infection control. There was an infection control lead person identified.

Good

Is the service effective?

Our findings

People using the service told us about the service they received. They told us their needs were met. One person said, "It is excellent, I've got a lovely room. I've worked as a volunteer in care homes and this is by far the most comfortable. The food is very good. I certainly haven't got any complaints". Another person said, "Sometimes it's lovely and enjoyable and amusing and then sometimes, I wonder what on earth I'm doing here. Today's good because there's a lot going on. On the whole, I think we're very well looked after. It's lovely actually". Relatives also said people received a service that met their needs. One relative said, "They're really good here, they look after (Relative) so well. I can't fault them. I've got no problems with this place at all. We were very lucky to get a place here."

People were cared for by staff who had received appropriate training to meet people's needs. Staff told us they had received the following training on top of the mandatory training courses that all staff had to complete: catheter care, bespoke Barchester dementia care training called 'SoKind', falls prevention training, venepuncture and communication. Training was scheduled in the next couple of months in first aid and cardio-pulmonary resuscitation, diabetes management and duty of candour training.

Training records showed that of the 45 care staff 24 had, or were working towards a qualification in health and social care. There was an expectation all new care staff would commence a health and social care qualification if they did not hold one, after completion of their probationary period. One staff member said they had just started to do their 'NVQ'. Newly appointed staff completed induction training. An induction checklist ensured staff had completed the necessary training to care for people safely.

The service had a programme of staff supervision and appraisal in place. There was a supervision plan for the whole year identifying dates for all nurses and care staff. These were scheduled on alternate months with one of the sessions being an annual appraisal. In general the planned sessions had taken place with most staff having already received three supervisions in 2015. However, some staff had only had one session. Records at the time of our inspection showed 86% of supervisions had taken place. Clinical supervision for the nurses was undertaken by the training manager, care staff received supervision from senior care staff.

People were able to make their own choices and decisions about their care. Information in people's support plans showed the service had assessed people in relation to their mental capacity. The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. The MCA is a law about making decisions and what to do when a person cannot make decisions for themselves. Staff were clear about asking people for consent and said if a person declined an activity they would try again later and inform the nurse in charge.

DoLS is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care. The legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty. These safeguards protect the rights of the people who live in a care home to ensure that the restrictions placed upon their freedom and liberty, were appropriately authorised and were in the person's best interests. The lead nurse in Memory Lane was able to tell us who was subject to a DoLS restriction, which applications were awaiting authorisation by the local authority and when those that had been agreed were due to expire.

It was evident from speaking with staff they knew each person's dietary likes and dislikes. In Memory Lane seven people needed a pureed diet and others needed a diet with a soft texture. Catering staff were informed of people's dietary requirements, had monthly nutrition meetings and were advised if a person's body weight had decreased. Fortified foods were provided when needed.

There was a four week rolling menu plan in place. All food was home cooked and fresh fruit and vegetables were always used. Menus were displayed in key sites throughout the home and on the dining room tables. People were asked what they would like to eat at the start of the meal. They were shown a plated meal to help them make their choice. People said, "The food is very good. The sort of food I like to eat", "We get plenty to eat and drink and can always ask for more". We received comments from several

Good

Is the service effective?

people regarding naming of the meals served. Two examples given were coq-au-vin and frittata. Particularly in Memory Lane, people may not understand what meal is being served. Food and drink was available at night times for those people who had not eaten well during the day

People's care records showed relevant health and social care professionals were involved with people's care. Plans were in place to meet people's needs in these areas and were regularly reviewed. An NHS dentist was organised to visit the home as and when needed but relatives were able to make their own arrangements if this was preferable. A foot care professional visited the service each week. Most people were registered with one GP practice and they had a planned visit to the home each week. The GP always had an introductory meeting with people when they moved to the service and could be called in at other times. Where people had lived locally prior to moving to Hunters Care Centre they were able to remain with the GP of their choice as long as the GP agreed to visit if needed.

The service had been designed to meet people's needs. The environment ion Memory Lane was suitable for people living with dementia. Bedroom doors were in the process of being replaced with white doors as recent research had shown this to be best for people living with dementia. Memory plaques were to be added to the doors to assist those people who were able to walk, to locate their own room. Memory Lane had a circular corridor around a contained courtyard, filled with sensory planting and several seating areas. The corridor had themed areas for example the seaside, a shop area, gardening, cars, household domestic tasks and the war years. There was appropriate signage to guide people towards toilets and bathrooms. The corridors leading off from the communal lounges/dining rooms towards the bedrooms, were not sign posted and the lighting was quite dim. People told us they felt the home and grounds were pleasant and met their needs. One person said, "Aren't we lucky that we've got so much room to walk around, inside and outside? I've no experience of anywhere else, but I think we're very lucky here".

Good

Is the service caring?

Our findings

People told us staff were caring. One person said, "The staff are lovely, very kind and caring. Relatives also said staff were caring. However, one relative had noticed a difference between staff. They said, "Some staff are really attentive whilst others are generally OK but sometimes have a grumpy day".

Staff said they felt the service provided was caring. A number of staff we spoke with said they would be happy for a relative of theirs to use the service. One of the nursing staff said, "This is the best team I have ever worked with, nurses here have principles, work really well together and feel valued'. A visiting healthcare professional said, "I would want my parents to live here. People seem very happy, there is a lot of activities going on and it is a fun place to be".

People were treated in a caring and respectful way. Staff were friendly, kind and discreet when providing care and support to people. People responded positively to staff, often with smiles, which showed they felt comfortable with them. We saw a number of positive interactions and saw how these contributed towards people's wellbeing.

Staff had received training on equality and diversity. People's care records included an assessment of their needs in relation to equality and diversity. The service always aimed to meet people's cultural and religious needs. Staff we spoke with understood their role in ensuring people's equality and diversity needs were met. One person explained they had specific dietary requirements and that these were met.

People were treated with dignity and respect. People's care plans included information to help staff understand what was important to them, and how they wished to be cared for. Care plans showed people had been involved in agreeing how their needs were met. These gave clear guidance for staff and we saw staff working in accordance with these plans. Staff usually addressed people by their first names. On occasions we heard staff using terms of endearments such as, 'my love'. It was not clear to us if this had been previously agreed with the person. Terms of endearment like this are often liked and appreciated.

However some people may not like these being used. Staff told us people were encouraged to surround themselves with their own furniture and have clothes they chose themselves available. One staff member said, "Having your own things around you, helps maintain a sense of self-worth".

The service operated a keyworker system, where a staff member was identified as having key responsibility for ensuring a person's needs were met. Staff told us this system allowed them to get to know the person they were keyworker for well and ensure the needs of the person were met.

Staff knocked on people's doors and either waited to be invited in, or if the person was not able to answer, paused for a few moments before entering. Staff respected people's right to privacy. We saw people's bedroom doors and doors to bathrooms and toilets were closed when people were receiving care.

We were told that a person who used the service had died on the day before we visited. People talked about this person over lunch. This showed staff had informed people of their death and recognised the importance of providing this information to them. The staff team always tried to attend funeral's when people died. One member of staff said, "It is important we pay our respects" and, "We get to know the families well".

Staff had received training in end of life care. Care records included an advance care plan. This encouraged people to plan their end of life care. These included details on decisions people had made on hospitalisation and where appropriate a DNACPR. A DNACPR is a way of recording the decision a person, or others on their behalf had made that they were not to be resuscitated in the event of a sudden cardiac collapse. Where 'do not resuscitate' decisions had been made the correct documentation was in place. This had been completed by the GP, the person (where appropriate) and their families. The service completed the 'Allow a natural death' yellow stickers and the nationally recognised resuscitation council red-rimmed forms. In Memory Lane a small number of the forms were waiting to be fully completed however the lead nurse already had this in hand.

Good

Is the service responsive?

Our findings

People told us the service responded to their individual needs. Throughout our inspection we saw staff responded appropriately to people's needs. This included answering call bells promptly and acting on people's requests. Relatives said the service was responsive to people's needs.

An individual assessment of people's needs was undertaken before they moved to the service. This was to ensure that the service had the appropriate equipment in place and the staff team had the necessary skills to meet the person's care needs. One person who had moved to the service from another county said there had been a discussion with the nurses on the ward and their relatives had provided information to the service.

People's care records were person centred. Care planning documentation had been prepared for each person and covered the full range of daily living needs. Plans were written in respect of communication, hygiene, mobility, skin integrity, nutrition and end of life care needs. Care plans also addressed mental health needs and any behavioural management needs. Those plans we looked at were well written and provided detailed instructions for the staff to follow. The person's named nurse was responsible for doing the care plan reviews and reporting changes in dependency to the registered or deputy manager. Information on how people had been involved in developing these plans was included in people's care records. Care plans included information on people's life histories interests and preferences. Staff said this information helped them to provide care and support in the way people wanted. Staff we spoke with were knowledgeable about people's life histories and their likes and dislikes.

Where people needed care and support with any wounds, wound care management plans were in place. These detailed the frequency of wound dressing changes and the products to be used. An evaluation of the wound was recorded each time it was attended to. Regular photography was used to assess if the wound was healing. Specialist tissue viability nurses had been consulted and it was evident their advice was being followed.

One person, who had been assessed as requiring individual support and additional equipment to meet their needs, was receiving one to one care during the night. Additional sensors to alert staff had also been put in place in accordance with the person's needs assessment.

Prior to our visit social care professionals from Gloucestershire County Councils had visited and raised concerns regarding the lack of an appropriate pain assessment tool for people living with dementia. We looked at the plan for one person who had a painful wound but was unable to verbally communicate the level of pain they were experiencing. Their plan stated they became restless and grimaced when they were in pain. The nurses had a copy of the abbey pain scale tool (an assessment tool for nurses to assess the level of pain a person may be experiencing when they cannot communicate) and used this as guidance when they are administering medicines.

In addition to their care plan, people had daily records in their rooms. These contained re-positioning charts, food and fluid intake charts and a topical creams/ointment administration records. Those we looked at had been completed appropriately and evidenced the care given. It was the responsibility of the care staff to record in the room folders. However nurses had a responsibility to check at the end of shift they were filled in.

People were involved in a range of individual activities. An activities plan was in place to ensure each person was able to engage in activities. Activities were arranged for both the Nursing Unit and Memory Lane. We saw examples of recent group activities. These included, arts and crafts, singers, belly-dancing demonstration, flower arranging, tea dances and walks with hawks. Photographs of people taking part in some of these activities were displayed on the walls in lounges. Activities people had taken part in were recorded in people's care plans. People told us they liked the activities and generally felt there were enough. One person said, "I think the activities are excellent, I think they do very well but you can't suit everybody all day, every day". They also said activities would be arranged if people made suggestions. They said, "The Activities Coordinator would be interested to know what we want to do". Another person said that they had enough to do and liked to walk around the grounds.

In the afternoon of day one we observed activity staff supporting eight or nine people participating in a cup cake decorating session. The interactions were positive and

Good

Is the service responsive?

friendly. There was a good rapport between the activity staff member, people and their relatives. Others were encouraged to join in and some dipped in and out of the session. We saw people being supported to attend the hairdressing salon throughout the day and we saw individual staff members spending short periods of time with people talking about a postcard, the weather, the fancy cake decorations or what they would like to drink.

People told us they were able to raise any concerns they had with staff or the manager. One person said, "I would talk to the manager, she's always about the home, always has a word and is very sympathetic". Meetings were held every three months. Records of these meetings showed the areas discussed most were food and activities. People who did not attend these meetings were given the opportunity of talking individually with a staff member. People's views, ideas and suggestions had been recorded and acted upon. However, at the most recent meeting people had expressed a desire to go out on more trips. The activities coordinator had also discussed this with us. The service had a minibus but due to the numbers of people, places were limited.

The provider had a policy on complaints and comments. A record of complaints was kept at the service. The provider had not received any complaints in the previous 12 months. The deputy manager said, "People tend to tell us if there is a problem and we put it right. We have reviewed and changed our communication systems to make sure information is shared with people who need to know". A relative said that communication, "Was brilliant", they told us they would talk to the manager if they wanted to know anything or had any worries. They said, "I can go to her at any time. The door is always open".

Good

Is the service well-led?

Our findings

Throughout our inspection we found the atmosphere in the home to be friendly, calm and relaxed.

The deputy manager and staff spoke passionately about person centred care and support and their vision for the service. At our initial meeting with the deputy manager on our arrival at the service, they said, "We have very dedicated staff who are passionate about this home, passionate about what they do and the people we look after. (Registered Manager's name) and I have the same ethos, to be open and transparent. If we haven't got something right, tell us and we'll put it right, we learn all the time, we change things all the time to make it better for the people who live here. This job is so much fun and so worthwhile". We saw people were provided with high quality care and support that was person centred.

People knew who the registered and deputy manager were and expressed confidence in their availability and effectiveness. Staff spoke positively about the manager and felt the service was well led. However, staff working with people on Memory Lane said they did not see the registered manager on the unit very often. They also felt that the nurses were rarely able to work alongside the care staff because of the amount of paperwork they had to complete and the length of time the medicine round took.

The provider operated an on call system for staff to access advice and support if the manager was not present. Staff confirmed they were able to contact a senior person when needed.

The provider had commented in their PIR that they planned to improve attendance at, and the effectiveness of staff meetings. Regular meetings were held. However, staff gave mixed feedback on how effective they were. There was a daily stand-up meeting at 9am attended by each unit lead and head of department. These meetings were kept as short as possible and focused on 'resident' and staff issues and any events that had occurred or were planned. Regarding other staff meetings, one staff member said, "We very rarely have staff meetings now but I don't know why. At the last meeting there were discussions about staffing numbers but nothing has changed". We saw records of two staff meetings for staff working with people on Memory Lane on 2 and 10 July 2015. However neither had been well attended. Another staff member said, "I have made suggestions about the way things could be done better and I have been listened to"

All accidents, incidents and any complaints received or safeguarding alerts made were and followed up to ensure appropriate action had been taken. The manager analysed these to identify any changes required as a result of any emerging trends.

The manager, deputy and senior staff knew when notification forms had to be submitted to CQC. These notifications informed CQC of events happening in the service. CQC had received appropriately notifications made by the service.

The policies and procedures we looked at were regularly reviewed. Staff we spoke to knew how to access these policies and procedures. This meant that guidance for staff was up to date and easy for them to use.

Systems were in place to check on the standards within the service. These consisted of a schedule of monthly audits. These audits looked at; medicines management, accidents and incidents, care records and fire drills. These audits were carried out as scheduled and corrective action had been taken when identified. Managers of the service carried out regular unannounced visits to the service at night. The deputy manager told us these visits were to assess if the quality of service provided to people was consistent throughout the day and night.

The provider commissioned an annual quality monitoring report, which was carried out by an independent market research organisation. This included results of surveys completed by people using the service, relatives and staff. The report for 2014 contained a comparison with the previous year. We saw the findings were generally positive. The deputy manager told us the 2015 report will be compiled when the surveys had been received.

Gloucestershire County Council's Quality Monitoring team carry out monitoring visits to the service. Following these monitoring visits the provider took action to address issues raised. The provider maintained a clinical governance database to review the quality of service provision and identify areas for improvement. Actions identified through internal and external quality processes were recorded on

Good

Is the service well-led?

this plan. The plan identified the actions to be taken, the person responsible and how success would be measured. We saw plans had been implemented and progress recorded and monitored.