Prime Life Limited

Braunstone Firlands Nursing Home

Inspection report

Gooding Avenue
Leicester
Leicestershire
LE3 1JS

Tel: 01162558809
Website: www.prime-life.co.uk

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

Braunstone Firlands is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulated both the premises and the care provided, and both were looked at during this inspection.

This inspection took place on two days 13 and 21 June 2018. The first day was unannounced, the second day was announced to ensure the registered manager was on duty.

Braunstone Firlands is registered to provide nursing and residential care and support for 24 older people with dementia and mental health needs. At the time of our inspection there were 20 people using the service.

Braunstone Firlands had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are '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 cared for safely and protected from abuse by a well-informed team of staff. Medicines are administered safely and people are protected from acquired infections by an active and well-trained staff group.

People were provided with a choice of meals that met their dietary needs. Staff were aware of people's dietary needs, and sought people's opinions about the menu choices in order to meet their individual cultural preferences and dietary needs. A range of activities were provided by staff however this could be on a more regular basis. Staff had had access to information and a good understanding of people's care needs. People were able to maintain contact with family and friends and visitors were welcome without undue restrictions.

Relatives we spoke with were complimentary about the registered manager and staff, and the care offered to their relations. People were involved in the review of their care plan, and when appropriate their relatives were included. We observed staff positively interacted with people at lunch, where people were offered choices and their decisions were respected. Staff had access to people's care plans and received regular updates about people's care needs. Care plans included changes to peoples care and treatment and people were offered and attended routine health checks, with health professionals both in the home and externally.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. They received induction and on-going training for their specific job role, and were able to explain how they kept people safe from abuse. Staff were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse.

Staff were aware of the reporting procedure for faults and repairs and had access to the maintenance contractors to manage any emergency repairs. The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours if an equipment repair was necessary.

The provider carried out quality monitoring checks in the home supported by the registered manager and home's staff. The provider had developed opportunities for people, their relatives and staff to express their views about the service. These included the views and suggestions from people using the service, their relatives and health and social care professionals.

We received positive feedback from the staff from the local authority with regard to the care and services offered to people at Braunstone Firlands.

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 and their relatives felt safe at the service. Potential risks to people were managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported. Medicines were stored and administered safely.

People's care was safely supported by sufficient numbers of staff. Environmental checks were carried out and improvements were made to ensure people were safe at all times.

Is the service effective?

Good

The service was effective.
People's needs were assessed and staff were trained to meet those needs.

People received a diet that met their individual needs. Staff were trained and supported to enable them to care for people safely and to an appropriate standard, and had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Staff provided care in a kind and sensitive manner and people's privacy and dignity were recognised.

Staff understood the importance of encouraging people's independence and their ability to make choices. People or their relatives were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service responsive.

Activities and pastimes had improved but further work was required to make them personalised.

People received personalised care that met their needs as they or their families were involved in planning how care and support was planned. Staff understood people's preferences, likes and dislikes, though not everyone had regular or consistent access to individualised activities.

People were confident to raise concerns or make a formal complaint when necessary and had access to a pain free death.

Is the service well-led?

Good

The service was well led.

The home had an open and friendly culture and people told us the registered manager and staff were approachable, friendly and helpful. People using the service and relatives had opportunities to share their views about the service.

The provider used audits to check people were being provided with good care and to make sure records were in place to demonstrate this. Premises audits were used methodically to plan for replacement of faulty or broken equipment.

Braunstone Firlands Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on two days 13 and 21 June 2018. The first day was unannounced, the second day was announced.

The inspection team consisted of one inspector.

We looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about. We also looked at other information sent to us from people who used the service or their relatives and health and social care professionals.

We contacted commissioners for health and social care, responsible for funding some of the people that lived at the home and asked them for their views about the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection visit we spoke with three people who used the service, four relatives, two visiting health professionals, the area manager, the registered manager, the deputy manager, the nurse on duty and three care workers. We also spoke with a visiting healthcare professional.

We looked in detail at the care and support provided for four people including their care records. We also looked at three staff recruitment records, and repair and maintenance records for the building, and the

audits undertaken by the registered and deputy managers.

Good

Is the service safe?

Our findings

At our last inspection in February 2017 we noted there were some issues that did not ensure all the people in the home were cared for safely. We saw that there were no automatic closers on bedroom doors and found bedroom doors propped open which placed people at risk in the event of an unplanned emergency such as a fire.

We saw that the provider had fitted automatic door closers to the majority of the home. These would close if activated in an emergency, protecting people from the risk of smoke or fire. There had been other improvements where corridor doors had been adjusted to close quietly and extractor fans have been installed to most toilet and bathing areas.

We saw that there were bedrooms on the ground floor without any call bell attached. We spoke with the registered manager who explained that those people were unable to use a call bell, and in one case a person had put the call bell cord around their neck placing themselves in danger of choking. The registered manager demonstrated through detailed records that these people were subject to regular staff checks.

The registered manager demonstrated through detailed records the staff completed regular checks of the building, fixtures and fittings. We viewed the on-going record of when items had been repaired or replaced. There was a maintenance team who undertook these repairs. Staff were aware of the procedure for recording and reporting faults and repairs. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained.

We saw where repairs had been completed, these were signed by the maintenance person who had carried out the repair. That meant the registered manager ensured people's safety through regular safety checks.

Staff were able to tell us about people's individual needs, and the support they required to stay safe. People's care records included risk assessments, which were reviewed regularly and covered areas related to people's health, safety, care and welfare. Care plans and associated risk assessments identified any changes in risks to people's health and wellbeing. The care plans provided clear guidance to staff in respect of minimising risk.

People and their relatives we spoke with told us that they felt safe and secure living in the home. One person said, "I am safe I trust the staff," and added, "They [staff] answer the call bell within two minutes and added I get good attention here." A relative said, "The staff are friendly, and everyone is protected and secure." A second relative said, "[Name] is safe the staff take good care of her."

We spoke with the staff about what they would do if they suspected someone was being abused at the service. One member of staff said, "I would make sure the manager or [named staff] was aware and if they didn't follow it up I would go to safeguarding at the council."

The provider had a safeguarding policy and procedure in place that informed staff of the action to take if

they suspected abuse. The company had also produced whistleblowing posters which were placed around the home. That included contact numbers which people could call and alert the Prime life head office to any allegation of abuse.

Staff we spoke with had received training in protecting people from harm and had a good understanding of what abuse was and their responsibilities to act on any concerns they had about people's safety. Staff knew the different types of abuse and how to identify them, and were aware of the whistle blowing policy and told us how they could use it if their concerns were not acted on by the management team. They also knew which authorities outside the service to report any concerns to if required, which would support and protect people. The registered manager was aware of their responsibilities and ensured safeguarding situations were reported to the Care Quality Commission as required.

Most people we spoke with did not voice any concerns over staffing levels. However, one person said, "They are always busy, they don't have time to talk." A relative said, "Staffing [numbers] were OK." A second relative said, "The deployment of kitchen staff has helped at lunch times."

We spoke with the registered manager who said the staffing numbers were under constant review, and they had applied for an additional member of staff to arrange individual as well as small group activities. During the inspection we spoke with a director of the company, who confirmed the proposal to increase staffing and appoint an activities co-ordinator. They would work alongside care staff and provide an additional member of staff at meal times whilst providing planned stimulation to the people in the home. At the point of writing the report we have not had confirmation of this appointment.

We found staff matched the diverse cultural background of the people in the home which ensured they were enabled to communicate their cultural needs. Staff were well deployed and assisted people throughout the day. At lunch time most of the staff in the home assisted with serving the meals and assisted people to eat.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for three staff. We found that the relevant background checks had been completed before staff commenced work at the service, which included the entitlement for nurses to continue to practice. That was then checked regularly through their appointment at the home.

People received the support they needed to take their medicines safely. One person told us staff supported them to take their medicines in line with their preferred choice. A relative said, "I've seen them give out the tablets to [name] they are happy to chat with you afterwards but don't like being disturbed at the time."

We observed staff supported people to take their medicines safely. Staff identified themselves to people and consulted with them regarding their medicines. People were supported to take their time to take medicines.

We saw that medicines were stored safely, administered on time, recorded correctly and disposed of appropriately. Protocols were in place for staff to follow and additional guidance on specific medicines which included known side effects or time-specific medicines. For example, where people needed to have their medicines 30-60 minutes before food and other medicines, protocols were in place to support staff to follow these specific administration instructions. Where people were prescribed medicines 'as and when required' [PRN] these were supported by detailed protocols to guide staff on stated dosages, maximum amounts and details of when they may be required.

Where people were prescribed creams we found records included a body map which indicated where the cream had to be applied. This is important as these medicines need to be applied to the affected area.

These records were checked and updated when the care plan was reviewed or when a change of medicine was made.

People were protected from the risk of acquired infections. A relative said, "I would like to emphasise the cleanliness of the home, it smells fresh."

People were protected by the prevention of control of infection. We saw people's rooms and communal areas were clean and well maintained with no unpleasant odours. Systems were in place to ensure the environment was regularly monitored for safety and hygiene. Staff followed infection control guidance when supporting people with personal care and demonstrated they understood food hygiene safety. Gloves and aprons were available around the premises and hand sanitizer dispensers were sited in communal areas for staff, people and visitors.

The registered manager stated any changes or outcomes from investigations would be documented and any lessons learnt fed back to staff. We saw from the minutes of staff meetings where outcomes were explained and staff prompted to ensure their practice was changed accordingly. The provider stated if necessary issues would be followed up at one to one meetings, to ensure people's confidentiality. Any development for the staff group would be in the form of a meeting as a team exercise, so all the staff could build on the learning experience.

Good

Is the service effective?

Our findings

Peoples care needs were assessed prior to being admitted to Braunstone Firlands and people were offered the support detailed in their risk assessments and care plan.

People we spoke with told us that the service was effective and they felt staff were capable in their role.

People and their relatives told us they were happy with the staff that supported them and their relatives. They told us they felt staff understood their needs and how they liked to be cared for.

Staff told us that they felt they had enough training and felt they had no gaps in their knowledge. Staff commenced their training with an induction programme which the registered manager confirmed was linked to the Care Certificate, which is a nationally recognised training course for care staff.

Staff then had access to courses relating to their role in health and safety, manual handling and food hygiene and infection control. We saw the training matrix which showed that all staff had updated essential training. The registered manager said the training matrix was regularly updated by their head office and was used to inform the management staff when further training was required.

Staff felt communication and support amongst the staff team was good. There were regular staff handover meetings which provided staff with information about people's health and wellbeing prior to commencing each shift. Staff also told us they felt supported through regular staff meetings with the registered manager. Staff supervision was used to advance staff knowledge, training and development by regular meetings between the registered manager and staff group. Clinical supervision for the nursing staff was undertaken by a qualified nurse. Supervision benefited the people using the service as it helped to ensure staff were more knowledgeable and able to care and support people effectively.

People told us they felt the meals provided were good. One person said, "I eat what I like it's tasty and I enjoy it." A relative said "Meal times are busy."

We found people were provided with a balanced and varied diet that helped maintain their weight. Records relating to nutrition and hydration were completed where people were at risk of malnutrition or dehydration. We saw where people had been referred to medical professionals if there were concerns about their nutrition.

We observed staff offer morning drinks to people and their visitors, and staff also offered snacks such as biscuits or fruit, and in some cases additional fortified drinks such as milk shakes, which helped people maintain their weight.

Menu preferences were discussed at regular 'resident and relative' meetings which are known as 'coffee mornings' between people using the service, their relatives and staff. Information about people's likes and dislikes of food and drink were recorded in their care plans, which were available to staff. This information

included any known food allergies and was also made available to catering staff. The staff were able to explain what this meant for people, and how the information was used. That helped to ensure meals prepared were suitable for everyone.

People were provided with the flexibility to eat in their bedroom, dining room or lounge. People were assisted to choose meals by staff providing a pictorial choice before lunch, and then presented people with a choice of plated meals. This demonstrated staff were able to communicate with people and promote choice. Meals were culturally appropriate and specialist diets were catered for.

We observed people at lunchtime. People looked relaxed throughout the meal and staff supported people to eat without rushing them. We saw some people had been provided with adapted cutlery and crockery to enable them to eat their meals independently. Some people required to be prompted and others required one-to-one assistance to consume their meal. This was done at a pace to suit the person, and staff were positioned appropriately to provide good eye contact.

Staff attended to people's requests when they requested second helpings or assistance with cutting their food into smaller pieces. We saw all staff maintained relaxed conversations with people throughout the meal. Fluids such as water and cordial were available in the dining area. Staff were observed to give choices to people throughout the meal.

We saw people's dietary needs had been assessed and where a need had been identified, people were referred to their GP, speech and language therapist (SALT) and the dietician. This ensured any changes to people's dietary needs were managed in line with professional guidelines. A visiting professional said, "Staff use good sense, they will use a teaspoon to feed people [where their swallowing was impaired."

Some people were recorded as having a poor appetite. Records showed how much the person ate and drank to ensure they had an adequate diet to maintain their health. The registered manager said if they had concerns about the health of anyone monitored this way, they would seek further medical advice. This approach ensured that people received effective support with their nutrition and hydration.

We spoke with a visiting health professional, who had been contacted by the registered manager to see people with specific health conditions. The visiting professional said, "They [staff] always follow through [medical] instructions," and "The staff are very clued up about the patients."

Staff felt the support and communication between the staff team was good. One member of staff said, "Staff work together to make the residents care a positive experience."

We saw there were daily handover meetings which provided staff with updated information about people's health and wellbeing. Staff also told us they were supported through regular staff and supervision meetings with the registered manager or lead nurse. Staff supervision can be used to support and check staffs' knowledge, training and development by meetings between the management and staff group. That benefited the people using the service as it helped to ensure staff were well-informed and able to care and support people effectively.

People told us they were happy with the staff that supported them. They told us they felt staff understood their needs and how they liked to be cared for. We observed people were offered the support detailed in their care plan and risk assessments.

People had access to health care services. People were happy with the access to medical services. A relative

said, "The nurse will phone the doctor." A second relative said, "Staff contact me if [named] is unwell." A third relative said, "We went to two other homes before visiting here, this place was ideal as it has medical help in the home."

Peoples' healthcare needs were identified and care plans were detailed and assisted staff in meeting peoples' health care needs. We saw the appropriate input and information from health care professionals was organised where necessary. There was evidence of care plan and health care plan reviews, these were routinely completed where required.

Records confirmed that people had access to a range of health care professionals including GPs, a specialist dementia team, speech and language (SALT) staff, district nurses, chiropodists, opticians, and dentists.

If staff were concerned about people's health they referred them to the appropriate health care services and accompanied them to appointments. That meant that people were supported to maintain a healthy lifestyle. A visiting professional said, "Staff use common sense the referrals are always appropriate, I have no concerns."

The home continues to go through the annual refurbishment programme. One visitor described some areas of the building as looking 'tired'. We spoke with the registered manager about this who said these areas were part of the annual redecoration programme and would be looked at by the companies decorating staff.

People who were able to respond told us that staff usually asked for consent. We observed a nurse asking for permission to do a blood test on one person. One person said, "They always check with me." Another person said, "Most [ask for permission] say it automatically"

Throughout our inspection we saw staff offered people choices and sought consent before they offered assistance. We saw staff used moving and handling equipment and transported people appropriately using a wheelchair. We saw that staff spoke with people, asked for permission to undertake care and kept people informed of what they were doing next. That showed training was put into practice and staff communicated with people effectively

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 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. The care plans we viewed showed evidence of MCA assessments. There was evidence of applications for Urgent and Standard Authorisations in respect of DoLS procedures. The DoLS applications showed evidence of considering peoples' particular needs. For example, there were applications to respond to needs such as ensuring personal care was provided and people leaving the care home. Urgent authorisations are sought to protect people until a proper assessment can be undertaken.

Staff were knowledgeable about how they supported people to make daily choices and decisions on a regular basis. Staff told us they did this to ensure the person was aware what was being offered, for example personal care. This showed staff understood the need to gain people's consent and agreement which involved them making informed day to day decisions.

Some of the people with DoLS restrictions placed on the m have 'positive conditions' added. We looked and saw the positive conditions were being met for all those in the home. For example, one person had to be offered to sit in the garden. Staff recorded when they asked the person and then if the person accepted or declined the offer. Another person had to be offered one to one activities, again these were recorded by staff when they took place.

Good

Is the service caring?

Our findings

People and their visiting relatives told us that staff were kind and compassionate and treated people living in the service with respect. One person said, "The carers are all very nice people."

A relative said, "Very friendly and efficient staff group." A second relative said, "They [staff] care in a relaxed manner."

We saw people were treated with kindness and compassion by a caring staff group. We observed staff interactions with people throughout the inspection which showed that staff were caring and helpful and people were treated with dignity. We heard staff asking people in a caring way if they required assistance by asking them, 'can I help you with that', 'are you comfortable', 'can I wash your face'. That demonstrated staff sought permission before offering care and attention to people.

We observed staff from both floors who assisted people to eat their lunch. We saw staff were seated at the correct height and maintained good eye contact and had maintained a conversation with people at appropriate times throughout the meal. The staff also ensured people's clothes were protected from food spillages, which assured their dignity. That demonstrated staff took steps to promote people's dignity. Toilet and bathroom doors were enabled to be locked, which ensured people had the choice to preserve their own dignity whist using these facilities.

Staff knew people and the name they preferred to be called. Some people were unable to express their views and opinions. Records showed that family members had been involved in care plan reviews and there was information in care plans to ensure people were referred to by their preferred name.

The registered manager confirmed some people's relatives were involved in care planning and reviews though some care records were not signed by the individuals or a family member. The registered manager told us care plans reflected people's needs and were reviewed when changes took place or at least monthly. Staff confirmed people were asked to take part in care plan reviews but only a few of them chose to take part in this process. The registered manager added that relatives and close family members were informed when people's health or wellbeing changed.

Staff were observed to be discreet when people needed assistance. They reassured people who were anxious and distressed and responded promptly, calmly and sensitively and were also seen to use distraction techniques to calm people. We later saw these care interventions written into care plans as one way of caring for people that were upset.

Staff were observed and heard to knock on closed doors and identified themselves before entering rooms and staff were observed to close doors when personal care was being offered. Staff responded to people's requests promptly, and were heard and observed to interact with people throughout the day. We saw where one person requested a shower late morning staff took her straight away. This again promoted the person's dignity.

Staff said there was a good staff team who knew people's needs and they all helped each other. They said they enjoyed working at the home and got on well with the people they supported. One member of staff said, "I am one of the newer staff, I know some staff have been here over ten years and some over fifteen years." That demonstrated a continuity of care.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2017 we identified improvements were required to people's individual activities.

At this inspection we saw there had been some improvements.

One relative said the felt as there was, "A lack of stimulation" for people reliant on care staff for support and felt their needs were not always addressed. However, some people and their relatives felt the care they were offered was individualised to them or their relation. A relative said, "We [the family] spoke and chose Braunstone Firlands as it met all our needs."

Care plan information included people's preferences and abilities to undertake activities. We completed some observations, and saw staff interacting with people on an individual basis. We also saw some people watched television whilst others read their daily paper or a book. We spoke with visiting relatives about their relations liked to do for activities. One person said, "I come in regularly and we go out for walks, it's what he misses and it keeps him occupied." A second relative said, "The staff make sure the music is turned on for them." A third relative said, "Staff take [named] out and involve him in various activities such as playing [musical] instruments."

Staff spoke with us about the activities they undertook with people. We saw that activities and pastimes were discussed with people prior to coming into the home in the 'getting to know you document'. This has been continued and discussed with people and their relatives at the monthly meetings. Changes have resulted in the menu system and general safety of the home. For example, relatives were asked not to prop open fire doors due to the security concerns and people being able to leave the home unsupported.

We observed staff spending quality time with some people and seeking to provide some meaningful stimulation. However, this was not regular or well planned and could be greatly improved on a personalised and individual basis.

We looked at people's care plans and found they included pre-admission assessments, which identified peoples' individual needs. The registered manager said these were carried out before people moved into the home, which ensured that staff could meet the person's identified care needs as soon as they moved into the home.

Care plans were individual and reflected people's cultural needs, and people's relatives felt they supported their relation. A relative said, "I think [named] is cared for very well." A second relative said, "The girls [staff] that deal with [named] knows them very well." A visiting professional said, "The staff are very responsive [named nurse] is on the ball, is very aware and gives us time to explain any [medical] problems."

Care plans were reviewed and updated periodically. We spoke with people and their relatives, and no one could remember being involved in care plan reviews. One relative told us they didn't have any input in their

relations care plan, and, "We leave it to the professionals." A second relative said, "I have not seen [named] care plan."

Care staff had access to people's plans of care and received updates about their care needs through daily handover meetings. The care files we viewed were comprehensive, and included regular reviews of their care and support needs.

Care plans included risk assessments, which gave clear guidance to staff in respect of minimising risk. For example, guidance about the food intake in response to choking risk and use of specific equipment to lessen the moving and handling risk. There was evidence where people's additional health needs had been responded to by staff. For example, referrals made to the GP's, dietician, specialist nurses (tissue viability nurses), Speech and Language Therapist (SALT) and community psychiatric nurse.

The registered manager was aware of the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager understood their responsibility to comply with the AIS. They were able to access and demonstrated information regarding the service in different formats to meet people's diverse needs. They spoke about communicating with speech and language staff (SALT) and providing people with alternative means of communication such as pictures. Staff knew people's individual communication styles, abilities and preferences. We saw staff listened to what people had to say and gave them time to respond to questions. The registered manager fully complied with the AIS.

Staff we spoke with were able to tell us what care and support people required, and were aware of people's current cultural needs.

Peoples relatives were aware of the concerns and complaints policy. The complaints procedure was advertised in the foyer of the home, that along with the manager surgeries and 'open door' policy, which allowed people a range of different ways they could speak with the registered manager.

No-one we spoke with could recall having to raise a formal complaint and felt that minor issues had been dealt with promptly. A relative said, "I would speak to the manager or nurse to sort it out." A second relative said, "I am convinced it would be taken seriously [and dealt with in the home] if not resolved I would take it to the head office."

The provider had systems in place to record complaints. Records showed the service had received five written complaints in the last 12 months. Most of these were about a poor variety of food choices which resulted in the food comments book being made available for visitors.

Outcomes had been provided for each complaint, and changes made to the service. There was a file in the foyer of the home that included a number of compliments about the care provided in the home. Most of these were not dated so we could not ascertain how old these were or when they were received at the service.

We saw there were regular meetings for the people and their relatives. These had been minuted and were available for people to refer to, and included the actions taken by the registered manager. For example, action taken where staff had addressed people inappropriately and other dignity issues.

People were supported to have a pain free death. Care plans provided guidance for staff as to the final

wishes of people. Seventeen people had a do not attempt resuscitation (DNACPR) advance decision and one person an advance decision care plan in place. This had been agreed with the persons relative as they did not have full capacity. That meant staff were clear about the person's wishes, and could inform any other appropriate authority of this. For example, if the person was admitted to hospital. That demonstrated people were supported to have a planned ending to their life that reflected their wishes. We spoke with two visiting professionals, one of whom said, "Palliative care is very good."

Good

Is the service well-led?

Our findings

The registered manager understood their responsibilities and displayed a commitment to providing quality care in line with the provider's vision and values. The registered manager worked alongside staff to monitor changes to people and develop their understanding of staff roles and implement change where needed.

People, their relatives and visiting health professionals we spoke with were complimentary about the registered manager and staff. People told us that the registered manager continued to be seen regularly helping in the home and was easy to talk with. A relative said, "The staff are good, can't think of how they could improve."

A member of staff said, "I like working with [registered manager] they are very supportive."

The provider's procedures for monitoring and assessing the quality of the service continued to operate at two levels. We viewed the checks and audits' the registered manager and staff undertook to ensure people received the appropriate care and support safely. These are then overseen by a director from the company and any shortfalls are reported to the board of directors and actions for changes discussed and planned.

The registered manager told us they conducted regular audits in order to ensure health and safety in the home was maintained. Checks included the medicines system, care plans, accidents and incidents, people's weight loss or gain and their nutritional and dietary requirements. We saw a number of records of the checks that had been undertaken that ensured the staff and caring process was safe for people.

The directors of the company were directly involved in the audit process. They undertake regular 'sit and see' observations. That is where a person more senior than the registered manager can sit and observe the care that is offered to people. The last 'sit and see' was in September 2017, and the outcome is displayed near the signing in board which gave 85% positive care. However, what it did not provide the public with was the 15% less positive care and how this would be addressed.

We received mixed views on the regularity of meetings for people, some relatives were aware of the monthly coffee morning meetings others not. None of the people we spoke with who used the service or their family or friends could recall being sent a questionnaire or survey. A relative said, "I can't recall a [quality assurance] questionnaire, but as far as I am concerned this place is ideal."

We received evidence from the registered manager from the most recent survey questionnaires that were sent out in 2017. Staff and management praise food menus and comments book in foyer.

The anonymous staff survey feedback was positive. People wrote about the home being a 'friendly place to work', having 'good relationships between staff and management.' Some areas for development were having fans or air conditioning fitted, more activities and time with the residents and a staff room for staff breaks. We spoke with the registered manager who said there was an action plan to address the time staff spent with people and suggestions had been made to staff where breaks could be taken.

We saw there were meetings held for the people who used the service and their family or friends where they were enabled to share their views about the service and influence its development. For example, in the February 2018 meeting a relative highlighted how hot the home got in the summer months. That resulted in the registered manager ordering more portable fans. People's families were also encouraged to bring in encouraged the families to bring in anything that may be of use for the staff to use as part activities for those individuals. We discussed that families where possible need to participate in making residents bedrooms more person centred. The registered manager also provided an 'open door' where people could discuss any issues or provide suggestions for improvements. This enabled people to be engaged in change to improve the home environment.

The service had a registered manager who understood their responsibilities in terms of ensuring that we were notified of events a provider had a legal responsibility to notify us about. The registered manager had a clear understanding of how they wanted the service and they were supported by the staff group, the regional director and other head office staff.

All staff all had detailed job descriptions in place and had regular supervision meetings which were used to support staff to maintain and improve their performance. There were separate supervision arrangements for the nursing staff as the registered manager was not qualified to undertake these. Staff had access to the provider's policies and procedures.

Staff were aware of their accountability and responsibilities to care and protect people and knew how to access managerial support if required. There was a system to support staff, through regular staff meetings where staff had the opportunity to discuss their roles, training needs and could discuss how the service was changing.

Staff told us that their knowledge, skills and practice was kept up to date. We viewed the staff training matrix, which showed that staff had received or had dates planned for refresher training. That included information on conditions that affected people who used the service and covered dementia awareness and behaviours that challenge.

Staff had access to people's plans of care and received updates about people's care needs through the daily staff handover meetings. The care files that we viewed were comprehensive, and showed regular reviews, which suggested the care process was well managed. The registered manager and staff were well thought off by professional healthcare staff, one visiting professional said, "Communication is good between the staff."