H & W Coastal Ltd

Fairhaven Care Home

Inspection report

Fairhaven residential care home
3 High park road
Ryde
Isle of Wight
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Tel: 01983568929

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27 September 2016

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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

Fairhaven care home is registered to provide accommodation and personal care for up to 21 people, including people living with a cognitive impairment. At the time of our inspection there were 21 people living in the home, 20 of which were over the age of 65.

This inspection took place on 27 September 2016 and was unannounced.

The home is set over two floors with the first floor being accessed via stairwells and a stair lift. The ground floor has a communal lounge/dining room and a quiet lounge for people to access. There was a safe and secure sensory garden and patio for the people to use. Seventeen of the bedrooms were single occupancy and two were shared.

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

The risks relating to people's health and were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

There was a robust recruitment process in place to help ensure that staff recruited were suitable to work with the people they supported. People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

People felt safe and staff knew how to identify, prevent and report abuse. Legislation designed to protect people's legal rights was followed correctly. Staff offered people choices and respected their decisions. People were supported and encouraged to be as independent as possible and their dignity was promoted.

People, relatives, and social care professionals were positive about the service people received. Medicines were managed safely and people received these as prescribed. People were positive about meals and the support they received to ensure they had a nutritious diet.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. Reviews of care involving people were conducted regularly. People had access to healthcare services and were referred to doctors and specialists when needed. The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided

sufficient information to allow staff to protect people whilst promoting their independence.

People and, when appropriate, their families were involved in discussions about their care planning, which reflected their assessed needs.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People's families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home. There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service provided both informally and through an annual questionnaire.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

There were systems in place to monitor quality and safety of the home. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

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.

The registered manager had assessed individual risks to people and had taken action to minimise the likelihood of harm in the least restrictive way.

People received their medicines at the right time and in the right way to meet their needs.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff showed concern for people's wellbeing in a caring and meaningful way and took practical action to relieve people's distress and discomfort.

Staff understood the importance of respecting people's choices and their privacy.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The registered manager adopted an open and inclusive style of leadership.

People, their families, health professionals and staff had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

Fairhaven Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection was unannounced and was carried out on 27 September 2016 by two inspectors.
Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with five people using the service and engaged with four others, who communicated with us verbally in a limited way. We spoke with three visitors at the time of the inspection and contacted two more following the inspection. We observed care and support being delivered in communal areas of the home. 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. We spoke with three members of the care staff, the registered manager, the deputy manager and the cook.

We looked at care plans and associated records for three people using the service. We also looked at a range of records relating to the management of the home including three staff recruitment files, records of complaints/compliments, accidents and incidents, policies and procedures and quality assurance records.

Following the inspection we made further contact with two health professionals and two social care professionals who provided feedback.

The home was last inspected in January 2014 when no issues were identified.

Good

Is the service safe?

Our findings

People told us they felt safe at Fairhaven Care Home. One person said, "Yes we are safe here". Another person told us, "Safe, oh yes"; they added "By my bed there is a bell. They tell me to use it anytime if I need [assistance]". Visitors also felt their relatives were safe. One visitor described how they did not worry when they were unable to visit and that if there were any problems someone from the home always contacted them.

Risks were managed safely. All care plans included risk assessments, which were relevant to the person and specified the actions required to reduce the risk. These included the risk of people falling, nutrition, moving and handling and developing pressure injuries. Risk assessments had been regularly reviewed and were individualised to each person. These procedures helped ensure people were safe from avoidable harm, whilst promoting their independence. We observed staff providing individual support for a person who was at high risk of falls. Care staff described actions they were taking to reduce the risk of falls for another person. We observed equipment, such as pressure relieving equipment being used safely and in accordance with people's risk assessments. Care staff said that repositioning was always undertaken by two staff and records confirmed this was the case.

People were supported by sufficient staff. Staffing levels consisted of four care staff including a senior care worker during the day and two staff at night. At busy times there was also an additional member of staff available and the registered manager and deputy manager were on hand to provide support if required. The registered manager said "We don't like to use agency staff if we can help it. The people need consistency and [staff] who know them". During each working shift there was a staff member allocated to 'shift leader' to ensure that staff were clear about their roles and responsibilities. Staff requirements were calculated on a weekly basis by the registered manager who used a dependency tool which incorporated the needs of the people living at the home.

People told us care staff were available when they needed them and we heard call bells were responded to promptly. One person said, "There are enough staff"; another person said, "They [care staff] come quickly if I need to use the bell, even at night". Visitors also said they felt there were enough staff. They told us the front door was usually answered promptly and staff had time to answer any questions they may have. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. There was always a member of care staff in the main communal areas, who was able to provide prompt support when people required this. At lunch time staff were on hand to offer encouragement and support when this was required. Where people required more assistance with meals, staff did not rush them and ensured they had time to eat their meals at their own pace.

The provider had a clear recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. Staff recruitment files showed that all appropriate checks, such as references, work history and Disclosure and Barring Service (DBS) checks had been completed. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. One person told us they had been invited to participate in the interviews for new staff. They told us

they had enjoyed doing this and hoped they would be asked to do so again.

People told us they were happy with the arrangements to receive their medicines. They told us they could get 'as required' medicines, such as for a headache, if needed. One person said "The staff do all that, they always remember". There was individual guidance as to how people liked to take their medicines. For example, we saw one person liked their tablets placed on a spoon and then into their mouth. We observed staff administering medicines to people and saw they followed best practice guidance by administering and recording them individually. Staff remained with people until they were sure all medicines had been taken.

Staff respected people's rights to refuse prescribed medicines. The registered manager described the action they had taken when one person had been refusing most of their medicines. The general practitioner had visited the person and amended their prescriptions so that only essential medicines were prescribed. However, the person was still refusing these and the registered manager had not informed the person's doctor about this. Another person had refused all their medicines including those for epilepsy on three consecutive days. The person's doctor had not been informed. We brought this to the attention of the registered manager who was aware that the doctor should have been contacted and took immediate action to notify the relevant doctors and agreed to address this with the staff.

Suitable arrangements were in place for obtaining, storing, administering and disposing of medicines. Staff administering medicines had received appropriate training and had their competency assessed. They had information to explain what each medicine was for and how it should be given. There were systems in place to ensure that medicines which should not be taken at the same time as meals were given before breakfast. Clear guidance had been developed to help staff know when to administer 'as required' medicines, such as pain relief and medicines to help reduce people's anxiety. We saw this information was individual to the person and would help ensure staff provided this to people when required. Records of medicine administration showed people were provided with paracetamol for a headache when required. Where medicines were prescribed with a variable dose, records stated how many had been administered. Systems were in place to ensure prescribed topical creams were applied where required. The dates that topical creams containers were opened were recorded including the date these should be discarded. This would help ensure people received these safely. Senior staff undertook weekly and monthly audits of medicines management.

The registered manager and staff had the knowledge necessary to enable them to respond appropriately to concerns about safeguarding people. They had received safeguarding training and knew what they would do if concerns were raised or observed. One staff member told us "If I had a concern I would go to the registered manager or directly to the local authority team if I needed to". Another staff member said "I would report concerns to the management, they always respond. If I had to I would whistle blow to the safeguarding team or CQC". Staff and the registered manager were aware of how to contact the local authority safeguarding team and when this may be necessary. Records confirmed the service reported any concerns to the appropriate authorities.

Suitable arrangements were in place to deal with emergencies. Personal evacuation and escape plans had been completed detailing the specific support each person required to evacuate the building in the event of an emergency. Improvements had been made to the home's fire detection equipment and emergency lighting systems.

Good

Is the service effective?

Our findings

People had confidence in the knowledge and the ability of staff to provide effective care. One person said, "Yes, they seem to know exactly what to do." Another person told us "They know what they are doing". Staff told us they received an induction and completed training when they started working at the service, including the completion of the 'Care Certificate'. The Care Certificate sets fundamental standards for the induction of adult social care workers. Staff received appropriate training to enable them to prove effective care to people. One staff member told us "I had lots of training when I started working here and this is often updated". Records confirmed this and showed that staff had access to further training and development opportunities.

The registered manager told us that the home had a training programme in place to highlight any pending and overdue training so that action could be taken to help ensure that training was always up to date. In addition, the registered manager was mindful of staff member's learning styles and would offer training to them in a format meeting their individual learning style. The staff had also been provided with specific training in relation to stroke care, Parkinson's disease and epilepsy care to promote efficient and effective care for people with these conditions.

Staff were supported appropriately in their role. They received regular supervision from the registered manager to enable both the staff and registered manager to discuss any training needs, issues or concerns they may have. A staff member told us "Supervision is good, helpful and I always feel I am listened to if I have any concerns".

People were supported to access healthcare services when needed. One person told us "If you need a doctor they will sort it out, you don't have to ask; they say they are going to do it if they think you aren't well". Records showed people were seen regularly by doctors, specialist nurses and chiropodists. The registered manager had arranged for an optician to visit the home enabling everyone who wished to have their vision checked and purchase new spectacles if required. Health information about people was known and records showed that, when required, staff consulted general practitioners and out of hours services, such as paramedics and the 111 service. When one person had required hospital admission, records showed a member of care staff had accompanied them to provide support and help medical staff understand the person's needs . Several people were diagnosed with epilepsy and at risk of seizures. There was individual guidance for staff within the medicine administration records as to the action they should take should any of these people have a seizure. This included calling emergency services if needed.

We received views from healthcare professional's about the care provided by the staff at Fairhaven Care Home. One professional told us "The staff will always contact us if they are concerned". Another healthcare professional reported within the provider's quality assurance questionnaire "The manager will always request health input appropriately".

Staff sought verbal consent from people before providing care and support by checking they were ready and willing to receive it. One person said, "They always ask if I'm ready to get up in the morning". Records

confirmed that staff complied with people's wishes; for example, one person who had had a shower the day before had declined personal care the next morning and staff had respected the person's decision.

Staff followed the principles of the Mental Capacity Act (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Some people had a cognitive impairment and assessments showed they were not able to make certain decisions. These included specific decisions around the delivery of personal care and the administration of medicines. Documentation relating to care staff making decisions on behalf of people included a record as to what action had been taken to try to assist the person to make the decision themselves. Staff had documented decisions they had made on behalf of people, after consulting family members and doctors where appropriate, which showed they were taken in the best interests of people.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. The registered manager had applied for DoLS authorisations where necessary and was waiting for these to be assessed and approved by the local authority. Information on the DoLS applications was clear as to why the application had been made. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way. For example, one person was at high risk of falling and staff were present with them most of the time. However, at lunch time, when the person was sat eating, staff moved away returning when the person stood up having finished their meal. This meant that the person received the support they needed but also had some 'space' in a safe way.

The registered manager and provider had considered the environment needs of the people in relation to their physical needs as well as those experiencing cognitive impairment. A safe and secure sensory garden and patio had been installed which could be easily accessed by the people. Doors to the toilets had been painted in bright colours to help people to find these more easily and the registered manager told us that this had a positive impact for some people's dignity and independence within the home.

People were positive about the meals at the home. They said they liked the food and they were able to make choices about what they ate. One person said, "I had seconds today, a big plateful, there is always extra if you want it". They added, "The cook asks everyone in the morning what they want and you can also have a salad if you don't want what's on the menu". Another person told us "The food is very good, I like it". People also told us staff gave them plenty of hot and cold drinks and they could ask for these if they wanted more. People received a varied diet including fresh fruit and vegetables. Care records included information about people's dietary preferences or specific needs and we saw these were met.

Where necessary, staff monitored the amount people ate and drank using food and fluid charts. Staff usually added up the amount people had drunk each day to assess whether this had been sufficient and these records were usually well completed showing people were provided with regular food and drinks. Some people needed to be encouraged to eat and this was done in a discrete and supportive way. People were offered choices; for example, at lunch time staff had two jugs of squash and asked people which they would prefer.

People's care files contained information in relation to people's last wishes and anticipatory care plans; these demonstrated that people and their relatives were involvement in this process. 'Do not attempt to actively resuscitate' decisions were in place where applicable and there was a system in place to access this information in an emergency to allow appropriate care and treatment to be provided. The care staff were aware of people's spiritual, cultural and religious needs in the event of their death.

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person said of the staff, "They are all lovely, very nice". Another person told us "The staff are all nice" and added "I can do whatever I like". A third person said "You could not wish for nicer staff, they have a sense of humour". They added: "With all the Queens money she couldn't be any better looked after than us". These comments were echoed by other people and visitors we spoke with.

Interactions between people and staff were positive and friendly. We saw staff kneeling down to people's eye level to communicate with them. We heard good-natured banter between people and staff showing they knew people well. At lunch time we saw a person tell staff the blackcurrant squash was not very strong. The staff member said "I'll put more in". This showed people felt confident to inform staff if they were not happy about something and that staff would accept their comments and act to rectify the problem. A person was concerned about where another person living at Fairhaven was as they were not in the communal room. Staff reassured the person and explained the other person was fine, was just having a 'lie in' and would be down later. People were clearly relaxed and comfortable in the company of staff. Staff gave people time to process information when choices were offered and did not rush people when supporting them.

Care and other staff knew what was important to people. The cook ask a person what they wanted for breakfast; the person stated a type of cereal. The cook then asked "With hot milk?" to which they person replied "Yes". This showed the cook knew what the person liked and was able to meet their individual needs. A section in care records detailed what was important for the person. Staff were aware of their preferences and where possible met these preferences. For example, one person's records stated they loved chocolate and a particular type of cake. Their door sign reflected this and in care records we saw they were provided with the cake they enjoyed. Staff told us the person enjoyed these treats and when we visited the person in their room staff gave the person some chocolate. Another care file stated "[The person] loves to have lie in's and breakfast and tea in bed" and daily records confirmed that the person had been provided with the opportunity to do this.

People were supported to bring their pets with them when they moved to the home. One person told us that the staff assisted them to care for their [person's] cat. Another person told us their pet parrot was living with them. Their care file detailed that family members would ensure the cage was kept clean. Daily notes showed care staff had provided some support with this when requested by the person. Being able to bring their pets with them to the home had a positive impact on their wellbeing.

Staff supported people to maintain family relationships. We spoke with three family visitors, who said they were always made to feel welcome and could visit at any time. Care plans also detailed people's spiritual beliefs or needs and any support they required in relation to this. There was information about a church service at the nearby church which was designed for people living with dementia. The registered manager was aware of how to access other religious leaders if required.

Staff treated people with dignity and respect and described the practical steps they took to preserve people's dignity when providing personal care. A person required some prescribed topical cream to be applied to their wrists for pain management. We saw staff ask them if they would like to move from the lounge to a more private place or if they were happy for the cream to be applied in the communal area. People told us they could request care from staff of a particular gender if this was important to them and this was recorded in their care plans. Care staff were aware of these preferences and said they were able to meet them.

Care plans included specific individual information as to how people's dignity should be maintained. For example, in one person's care plan we saw "[The person] likes to look nice, chooses outfits with the assistance of care staff". Another said "[The person] likes to have make up, jewellery and perfume on daily". A third person's care file detailed how they should be supported to dress appropriately for their modesty. We saw staff supported this person to ensure they were appropriately covered, as detailed in their care plan. Staff were seen to respect people during interactions. A staff member apologised for knocking into the chair of a person at lunch time and thanked people after they had taken prescribed medicines. People were offered the choice and informed before clothing protectors were used at lunch time.

People's privacy was respected at all times. Before entering people's rooms, staff knocked, informed the person who they were and sought permission from the person before going in. Care plans directed staff to ensure people were kept covered as much as possible during personal care. A person confirmed that staff used these techniques. Confidential care records were kept securely and only accessed by staff authorised to view them. One bedroom was shared by two people. A privacy screen was available in this room and staff confirmed they used it when necessary. People told us staff always remembered to close curtains and doors before providing care.

People's independence was promoted. At lunch time staff encouraged a person to eat without taking over. Care plans specified what people could do for themselves and what they needed help with. For example, one stated that the person could drink independently if provided with a straw in all drinks. At lunch time we saw the person had a straw in their drink. Staff offered to cut up another person's meal they were then able to eat independently. One person told us staff gave them the flannel to enable them to wash their own face but said staff "help with the rest as I find that hard".

When people moved to the home, they and when appropriate their families were involved in assessing, planning and agreeing the care and support they received. People, or where appropriate their relatives, had signed care plans to show involvement and agreement with their care plan. Comments in care plans showed this process was on-going. People told us they had the opportunity each month to talk to a named member of care staff about their care and how this was provided. Family members told us they were kept up to date with any changes to the health of their relatives. They told us they received a monthly phone call from a member of staff to update them about any changes and check that they were happy with the way their relative was being cared for. Care records contained a note showing these discussions had occurred.

Staff showed concern for people's wellbeing in a caring and meaningful way and took practical action to relieve people's distress and discomfort. Two people became distressed during our visit and staff members responded immediately providing them with reassurance, comfort and additional support as required.

There was an easily accessible 'comments book' for people, their relatives and visitors to use. Comments within the book included "[My relative] is treated with exceptional care and kindness", "Lovely team of carers, wonderful care", and "The staff are polite, helpful and welcoming; they will always help in anyway".

Good

Is the service responsive?

Our findings

The service was responsive.

People received personalised care and support that met their needs. One person said the staff "are always very helpful". When people's needs changed staff noted this and took appropriate action. For example, we saw that one staff member had noted one person had a sore eye which may have been infected. They requested the person's general practitioner to visit and the person was prescribed eye drops which they received.

Procedures were in place to ensure that people were monitored closely following falls, especially if they had bumped their heads. Records confirmed these procedures were followed when required. Another person's care records detailed the action staff had taken when the person had been unexpectedly found unresponsive. Emergency services had been called and a staff member had accompanied the person to the hospital accident and emergency department.

Staff demonstrated a good awareness and a clear understanding of people's individual support needs and how each person preferred to receive care and support. One person's care file stated "[The person] needs prompting and minimal assistance with person care, but give space for them to be as independent as possible". When we discussed this person's needs with a member of the care staff they were able to describe how they provided support to this person which was reflective of the information in the care file. Another member of staff told us "[The person] responds better to male staff so when there is a male carer on shift they will always support this person with personal care". This was also reflected in the person's care file.

People's care files provided information to enable staff to provide appropriate care in a consistent way. They were individualised and detailed people's preferences, such as sleeping arrangements, likes, and dislikes. Care plans and related risk assessments were reviewed monthly or more frequently if required by the registered manager to ensure they reflected people's changing needs. Records of care confirmed that people received appropriate care and staff responded effectively when their needs changed. People or their relatives had signed care plans demonstrating they had been involved in identifying how their needs would be met. Care plans and related records contained specific individual guidance where necessary. For example, several people had a history of seizures. Information with the medicine administration records provided care staff with specific guidance as to the actions they should take if the person experienced a seizure. This directed staff to contact paramedics if the seizure lasted longer than a specific time.

Staff were kept up to date on people's needs. We joined the staff handover meeting between the morning and afternoon care staff. Information was provided to the staff in a clear and informative manner in relation to any particular concerns about individual people. During this handover the staff provided support to each other as well as having clear discussions about the best ways to support the people they cared for. For example, one person had declined food at lunch time when it was offered by two members of care staff. It was suggested that a particular staff member who had just arrived try again as they had a good rapport with the person. During handover staff were given clear instructions about their roles and responsibilities for the

afternoon and all actions needed or areas of concern were documented within the 'handover book'.

People were provided with appropriate mental and physical stimulation. The registered manager explained that they purchased activities from external providers, such as singers and entertainment and staff also organised regular activities. These included gardening, cooking, reminiscence, games, music, armchair exercises and reading papers and letters. The registered manager told us that the service aimed to maintain lifelong hobbies as much as possible for people and this was confirmed by a relative who told us "[My relative] used to enjoy reading and painting and is given the opportunity to do this at Fairhaven". Another relative said "I visit the home regularly and there is always something going on. The other day some of the people were making cakes, the staff are always chatting and involving [people] in things". Representatives from the local church visited regularly and provide a church service to those who wished to attend. People were also provided with opportunities to go on outings to the local town, for walks, drives, or to garden centres or cafes. The registered manager told us that during a resident meeting, people had expressed a wish to attend a local event; this was arranged, but when the transport arrived many people declined to go and their wishes were respected.

The registered manager had actively sought support to aid the welfare of a person who occasionally displayed behaviour that staff or other people using the service found distressing. Appropriate professionals had been involved in the development of effective care planning, which included increased one to one support and the provision of a befriender volunteer from a charitable group. This resulted in a reduction in frequency of the behaviour's which had a positive impact on the person and other people living at the home.

The provider was in the process of decorating people's bedrooms and making them more person-centred. People had been actively involved in choosing colours and furnishings, such as bedding and curtains and people's choices have been respected. Where people were unable make these decisions independently, staff gained information from families and loved ones and referred to the information within the care files around their likes and dislikes. People were also involved in choosing new furniture for the communal areas of the home, such as the quiet lounge. The registered manager provided people with 'samples' to help them choose the covering for the settee. The registered manager told us "I was not keen on the decision that was made, but when the settee arrived I really liked it". This demonstrated that the people's decisions and choices were respected and acted upon.

The registered manager sought feedback from people's families on an informal basis when they met with them at the home or during telephone contact. A family member told us "The registered manager will always keep us updated and will phone us regularly to let us know how [our relative] is". Another family member said "If I was concerned about anything I would go straight to [the registered manager]. She will always listen and act, I would definitely be able to approach her."

The registered manager also sought formal feedback through the use of quality assurance survey questionnaires sent to people, their families and staff. We looked at the feedback from these surveys, which was all positive in respect to the care they people received. Comments included 'We always find the staff kind and helpful', 'Polite, friendly and welcoming staff' and 'The care couldn't be better'. Where concerns and issues were raised, such as one comment that said, 'Would like window in [my relative's] bedroom to be double glazed', this was responded to and we saw a new double glazed window had been fitted.

People knew how to complain and there was a suitable complaints procedure in place which included information on how to make a complaint and details of external organisations, such as the Care Quality Commission, where people could raise concerns. One person told us, "I've never made a complaint. If I was

unhappy about something I would just talk to the manager". Another person said, "I've got no complaints." Visitors said that they would talk to a member of staff or the manager if they had any concerns. There was information about how to complain available for people or visitors in the home's hallway. Where people were unable to complain independently, support was provided through advocacy services and one to one support from staff. The registered manager said there had been no formal complaints in the preceding year, but was able to describe what action they would take if they received a complaint. We viewed the records relating to historic complaints, which showed that they had been investigated appropriately. The person who had raised a previous complaint was provided with a written response apologising and detailing the action the registered manager had taken to rectify the problem.

Good

Is the service well-led?

Our findings

People, their families and health and social care professionals told us they felt the service was well-led. One healthcare professional said of the service, "It's come on leaps and bounds since [the registered manager] has been in post", and another said in response to a survey conducted by the provider, "Excellent manager, helpful and friendly". A family member whose relative had a cognitive impairment told us, "The registered manager is always fully involved and would not hesitate to get advice and support from others to help care for [my relative] if needed". A member of the care staff said, "Since the registered manager has been in post there has been a real improvement, not just the way the home looks but the staff moral and the quality of the care".

There was a clear management structure, which consisted of a registered manager, deputy manager, senior care staff, care staff and support staff. Staff understood the role each person played within this structure. The registered manager was aware of, and kept under review, the day to day culture in the service, including the attitudes and behaviour of the staff. This was done through observations of care provision, working alongside staff and regular staff supervision. One staff member described the registered manager and deputy manager as being "very much present, helpful and understanding". The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One staff member told us "The running of the home is really good; if I was concerned about anything I would go straight to [registered manager] who will always take action". Another staff member said "We are like a little family. I have confidence in the management; they [registered manager and deputy manager] are so accommodating, supportive and caring".

Family members told us they were given the opportunity to provide feedback about the culture and development of the home and all said they were happy with the service provided. People and their relatives were actively involved in developing the service. The registered manager held a 'service user meeting' every three months, to which people, their families and advocates were invited. These meetings used to be held more frequently, but following feedback from people and their relatives the decision was made to reduce the frequency of these meetings. The meetings were chaired by the management team and meeting minutes were produced. The meetings provided people and their families the opportunity to discuss issues or concerns, as well as activities, meal plans and the running of the home.

The provider was engaged in running the service and their vision and values were built around supporting people as individuals, ensure people are happy, well cared for, respected and felt at home. Care staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed.

The provider had suitable arrangements in place to support the registered manager; for example, regular

meetings, which also formed part of their quality assurance process. The registered manager told us they receive support from the provider who visited weekly, was always available on the phone for advice and would attend immediately if needed. The registered manager said they also felt supported by the staff. The registered manager kept up to date with current best practice by attending training events, liaising with other home managers through the care home association and by reading relevant circulars and updates provided by trade and regulatory bodies.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. This included audits of key aspects of the service such as medicines, infection control, the environment, people's care plans, health and safety and staff training. Where audits had identified concerns, action plans were developed to ensure improvements were made. In addition to pre-planned audits, the registered manager also completed infection control spot checks frequently, and random bed checks daily to ensure the staff were working within guidelines to prevent the spread of infection.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The registered manager understood their responsibilities and was aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area and on the provider's website for people and visitors to view.