Roseberry Care Centres GB Limited

Church View (Bishop Auckland)

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 1, 2 and 4 June 2015 and was unannounced. This meant the staff and the provider did not know we would be visiting. The home was last inspected by CQC on 21 February 2014 and required improvements to meet people's nutritional needs. The registered provider has changed since our inspection in 2014.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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

Summary of findings

and associated Regulations about how the service is run. The registered manager was not present during our visit however the deputy manager was present and was the acting manager at the time of the inspection.

Church View is a purpose built, two storey care home in the village of South Church, close to Bishop Auckland. It provides residential care for up to 45 older people over two floors. On the day of our inspection there were 43 people using the service.

People who used the service and their relatives were complimentary about the standard of care at Church View. Everyone we spoke with told us they were happy with the care they were receiving and described staff as very kind, respectful and caring.

There were sufficient numbers of staff on duty in order to meet the needs of people using the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Training records were up to date and staff received supervisions and appraisals.

There were appropriate security measures in place to ensure the safety of the people who used the service. The provider had procedures in place for managing the maintenance of the premises.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home but could be more suitably designed for people with dementia type conditions.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We looked at records and discussed DoLS with the manager, who told us that there were DoLS in place and in the process of being applied for.

We saw mental capacity assessments had been completed for people and best interest decisions made for their care and treatment. We also saw staff had completed training in the Deprivation of Liberty Safeguards.

People were protected against the risks associated with the unsafe use and management of medicines however the storage of controlled drugs would benefit from further improvement.

We saw staff supporting and helping to maintain people's independence. People were encouraged to care for themselves where possible. Staff treated people with dignity and respect.

People had access to food and drink throughout the day and we saw staff supporting people in the dining room at meal times when required.

The home had a programme of activities in place for people who used the service.

All the care records we looked at showed people's needs were assessed. Care plans and risk assessments were in place when required and daily records were up to date.

We saw staff used a range of assessment tools and kept clear records about how care was to be delivered.

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists.

The provider consulted people who used the service, their relatives, visitors and stakeholders about the quality of the service provided.

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?
The service was safe.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. There were sufficient numbers of staff on duty in order to meet the needs of people who used the service.

Staff had completed training in safeguarding of vulnerable adults and knew the different types of abuse and how to report concerns.

The provider had procedures in place for managing the maintenance of the premises.

Good

Is the service effective?
The service was effective.

Staff were supported to provide care to people who used the service through an induction and a range of mandatory and specialised training.

People had access to food and drink throughout the day and we saw staff supporting people when required.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home.

Good

Is the service caring?
The service was caring.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

People who used the service and their relatives were involved in developing and reviewing care plans and assessments.

Bedrooms were individualised with people's own furniture and personal possessions.

Good

Is the service responsive?
The service was responsive.

Care plans and risk assessments were in place where required.

The home had a full programme of activities in place for people who used the service.

The provider had a complaints procedure in place and people told us they knew how to make a complaint.

Good

Is the service well-led?
The service was well-led.

The provider had a quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Good

Summary of findings

Staff we spoke with told us they felt able to approach the manager and felt safe to report concerns.

People who used the service had access to healthcare services and received ongoing healthcare support.

Church View (Bishop Auckland)

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 1, 2 and 4 June 2015 and was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by an adult social care inspector, a specialist adviser in nursing and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses this type of care service. Our expert had expertise in older people's services.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including commissioners, safeguarding staff and the infection prevention and control team. No concerns were raised by any of these professionals.

During our inspection we spoke with eleven people who used the service and 5 relatives. We also spoke with the acting manager, the regional manager, the activities co-ordinator, five care staff, the administrator, the hairdresser, the cook and a domestic.

We looked at the personal care or treatment records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff.

We reviewed staff training and recruitment records. We also looked at records relating to the management of the service such as audits, surveys and policies.

For this inspection, the provider was not asked to complete 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 improvements they plan to make. We spoke with the manager about what was good about their service and any improvements they intended to make.

Good

Is the service safe?

Our findings

People who used the service and their relatives told us, "Yes, I do feel safe in here" and "I know [Name] is safe and is being well cared for".

Church View is a two storey, detached building set in its own grounds. The home comprised of 45 single bedrooms, all of which were en-suite. We saw that the accommodation included several lounges, two dining rooms, two communal bathrooms and shower rooms on each floor. All were spacious and suitable for the people who used the service. There was also a garden with a patio area. We saw the home was clean and general well maintained. We saw that entry to the premises was via a locked, key pad controlled door and all visitors were required to sign in. This meant the provider had appropriate security measures in place to ensure the safety of the people who used the service.

Equipment was in place to meet people's needs including hoists, pressure mattresses, shower chairs, wheelchairs, walking frames and pressure cushions. We saw the slings and hoists had been inspected in accordance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) in May 2015 and the passenger lift in April 2015. We saw window restrictors, which looked to be in good condition, were fitted in the rooms we looked in to reduce the risk of falls and wardrobes in people's bedrooms were secured to walls. Maintenance checks had been carried out for window restrictors, in May 2015. Call bells were placed near to people's beds or chairs and were responded to in a timely manner. The nurse call system had been serviced in May 2015.

We looked at the records for portable appliance testing, emergency lighting, periodic electrical certificate and gas safety certificate. All of these were up to date. Accidents and incidents were recorded and the information reviewed in order to establish if there were any trends. Hot water temperature checks had been carried out and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014.

We saw a fire emergency plan on each floor which displayed the fire zones in the building. We saw fire drills were undertaken in 2015 and a fire risk assessment was in place. Weekly fire alarm checks were completed and checks on fire extinguishers were up to date. We looked at the personal emergency evacuation plans (PEEPs). The PEEPS were reviewed on a monthly basis. They described the emergency evacuation plan for each person who used the service. This included the person's name, date of birth, room number and floor, number of staff required to assist them, any assistive equipment required and personalised evacuation procedure. This meant the provider had arrangements in place for managing the maintenance of the premises and for keeping people safe.

We discussed staffing levels with the acting manager and the regional manager. The regional manager told us that the levels of staff provided were based on the number and dependency needs of people and the design and layout of the home. Staff absences were covered by existing home staff. We saw there were eight members of care staff on a day shift, which comprised of two senior care assistants and six care assistants. The night shift comprised of a senior carer and four care assistants. The home also employed an administrator, a cook, a kitchen assistant, an activities coordinator, two domestics, a laundry assistant and a maintenance man. We observed plenty of staff on duty for the number of people in the home. A person told us, "Staff are always busy".

We looked at a copy of the provider's safeguarding adult's policy, which provided staff with guidance regarding how to report any allegations of abuse and a safeguarding risk threshold was displayed on the notice board in the staffroom. We saw that where abuse or potential allegations of abuse had occurred, the registered manager had followed the correct procedure by informing the local authority, contacting relevant healthcare professionals and notifying CQC. We looked at four staff files and saw that all of them had completed training in safeguarding of vulnerable adults and whistleblowing. The staff we spoke with knew the different types of abuse and how to report concerns. This meant that people were protected from the risk of abuse.

We looked at the selection and recruitment policy and the recruitment records for four members of staff. We saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS), formerly Criminal Records Bureau (CRB), checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was

Good

Is the service safe?

obtained from each member of staff, including copies of passport, birth certificate, driving licence, marriage certificate and utility bill. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the service had arrangements in place to protect people from harm or unsafe care.

We looked at the management of medicines. We found that the service had up-to-date policies and procedures in place, which were regularly reviewed to support staff to ensure that medicines were managed in accordance with current regulations and guidance. The home operated a monitored dosage system of medication. This is a storage device designed to simplify the administration of medication by placing the medication in separate compartments according to the time of day. We saw photographs attached to MAR charts of people in the home who took medication. This helped care staff to identify the correct person to administer each medicine to and reduced the risk of errors. MAR charts showed that on the day of the inspection care staff had recorded when people received their medicines and entries had been initialled by staff to show that they had been administered. We saw evidence that relevant staff had received 'safe handling of medicines' training and that their competency to manage medicines was assessed every six months. Medicines requiring storage within a locked fridge were stored appropriately and the temperature of the fridge and treatment room were monitored regularly. These measures ensured that staff consistently managed medicines in a safe way.

Appropriate arrangements were in place for the administration and disposal of controlled drugs (CD), which are medicines which may be at risk of misuse. The controlled drugs book was in good order and medicines were clearly recorded. We saw the storage of controlled drugs did not comply with the misuse of drugs [safe custody] regulations [1973] for example, to provide an appropriate lock and key for the cupboard. We also saw that care staff, who had authorised access, held the key to the outer CD cupboard, however this was not separate from the keys to the medication room which did not comply with the provider's medicines policy, which stated "The keys to the controlled drugs cupboard must be kept on the designated person at all times and must be separate from the keys to the medication room". We discussed this with the acting manager who told us this would be actioned. This meant that the provider administered, managed and disposed of medicines safely however the storage of controlled drugs would benefit from further improvement.

Good

Is the service effective?

Our findings

People who lived at Church View received care and support from trained and supported staff. People we spoke with told us, "They're all nice girls", "They do the best they can" and "Staff are brilliant for what they get".

We looked at the training records for four members of staff and we saw that staff had received an induction which covered a tour of the home, an introduction to the residents, fire safety, a copy of the general social care council's code of practice and the provider's policies, for example, confidentiality, safeguarding, moving and handling, bedrails and whistleblowing, care plans, call bell system, residents choices and handover procedures.

We saw that mandatory training was up to date. Mandatory training included moving and handling, first aid awareness, fire safety, medicines, safeguarding, infection control, health and safety/risk assessment, food hygiene, moving and handling, infection control and control of substances hazardous to health (COSHH). Records showed that most staff had completed either a Level 2 or 3 National Vocational Qualification in Care. In addition staff had completed more specialised training, in for example, equality and diversity, information governance, customer care, pressure area care, dementia awareness, dignity and respect and challenging bahaviour.

Staff told us, "We are always having training", "I have done my safe handling of medicines" and "The dementia training was interesting and would like more training in this area". We saw the training matrix which displayed when training was completed and when renewals were due.

We saw most staff had received supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. This meant that staff were properly supported to provide care to people who used the service.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We looked at records and discussed DoLS with the manager, who told us that there were DoLS in place and in the process of being applied for. We found the provider was following the requirements in the DoLS. We also saw staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

We saw mental capacity assessments had been completed for people and best interest decisions made for their care and treatment. One person's record we looked at provided evidence that, where necessary, an assessment had been undertaken of the person's capacity to make particular decisions and it had been deemed that the person had capacity. This meant that the person's rights to make particular decisions had been protected, as unnecessary restrictions had not been placed on them.

People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining room at lunch time when required. People were supported to eat in their own bedrooms if they preferred. We saw daily menus displayed on the notice boards in the dining rooms which detailed the meals available throughout the day. We observed staff giving residents a choice of food and drink. One relative told us that her mother had put on weight since coming into the home.

We observed staff chatting with people who used the service. The atmosphere was not rushed. We spoke with the cook and staff who told us about people's special dietary needs and preferences, for example, she told us, "[Name] doesn't like jelly", "I make [Name] a mousse with goats milk as they are intolerant to cow's milk" and "[Name] doesn't like cream so I do cake with custard". We saw one lady who could not tolerate wheat being offered special biscuits at mid-afternoon tea time.

We looked at records which included notifications to the kitchen regarding people's food likes, dislikes and dietary needs. For example, "Thick puree diet, food to be cooked until soft and pureed to a thick smooth lump free consistency", "I have type 2 diabetes so my sugar intake must be monitored", "Only likes small portions offered to them", "Encourage fluid intake and high calorie snacks", "Offer oral intake little and often" and "High calorie additive prescribed by GP to be added to drinks". We also found care plans contained information on people's dietary needs and the level of support they needed to ensure they received a balanced diet, for example, "Supervise at mealtimes to reduce choking risk".

Good

Is the service effective?

People who used the service and their relatives told us, “The meals are nice”, “Good food, plenty of it”, The food’s ok” and “Some days the food is excellent, other days it’s quite good”. From the training matrix, we saw staff had completed training in food hygiene, nutrition and textured diets.

Where people were identified as being at risk from malnutrition their food and fluid intakes were closely monitored. We saw records which showed exactly what and how much had been consumed. We also saw supportive oral care plans in place. People were weighed in accordance with the frequency determined by whether they were at risk of malnutrition. This information was used to update risk assessments and/or refer to the GP/dietician for additional support/advice if weight loss was identified.

One person’s care file recorded, “Remains on weekly weights and has lost weight again. [Name’s] GP has been made aware” and we saw evidence that this had been actioned.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home but could be more suitably designed for people with dementia type conditions. We discussed the design of the home with the acting manager. She told us about the plans she had to refurbish the upstairs unit and provide visual stimulation for people which included improved lighting in the corridors, contrasting wall and fixture colours, improved signage on doors and walls and the provision of attractive and interesting memorabilia and artwork.

Good

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the standard of care at Church View Care Home. Everyone we spoke with told us they were happy with the care they were receiving. People told us, "The staff are very good", "The girls are lovely" and "The staff are very kind".

People we saw were well presented and looked comfortable. We saw staff talking to people in a polite and respectful manner. Staff interacted with people at every opportunity, for example encouraging them to engage in conversation or asking people if they wanted help when they passed them in the lounges or in their bedrooms. A resident told us, "It's alright here. There's everything you want. The staff are alright. I have no complaints".

We observed good interaction between staff and people who used the service. Staff provided care in a patient, kind, and compassionate manner, supporting people to maintain their independence where possible. We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. This meant that staff treated people with dignity and respect.

Staff demonstrated they understood what care people needed to keep them safe and comfortable. We saw people being given choices for example, when to have a bath or what to have to drink. A visiting professional told us, "Staff are really good and it's obvious they want to be here. I would stay here myself".

We saw the bedrooms were individualised with people's own furniture and personal possessions and the service provided a lounge on the ground floor of the home where visitors and relatives could meet with people who used the service in private.

A member of staff was available at all times throughout the day in most areas of the home. Staff focussed on people's needs. Staff we spoke with told us, "I get satisfaction from helping the people", "I enjoy chatting to the residents" and "I love helping the residents".

We looked at daily accountability notes. They were concise and information was recorded regarding basic care, hygiene, continence, mobility and nutrition. The daily notes were written in black ink, dated, timed and signed and were completed by the staff providing care and support. This meant that people were appropriately cared for and supported as records were complete.

Some people and their relatives were aware of the care plans. We saw Do Not Attempt Resuscitation (DNAR) forms were included in two people's care records and we saw evidence that the person, care staff, relatives and healthcare professionals had been involved in the decision making. We saw a DNAR form for one person had been completed in a hospital setting. We discussed this with the acting manager who contacted the General Practitioner to discuss, since DNAR forms should be reviewed if the care setting changes. We saw end of life care plans, in place for people, as appropriate and that staff had received training in end of life care. This meant that information was available to inform staff of the person's wishes at this important time to ensure that their final wishes could be met.

We saw information for residents and their relatives prominently displayed on notice boards throughout the home including, for example, chiropody/podiatry services, eye examination services, complaints, advocacy services, hairdressing services and the provider's newsletter.

Good

Is the service responsive?

Our findings

People who used the service felt their health needs were being met. A relative who was worried about his wife's weight loss told us, "The staff are doing their best and they have recently sought medical advice for her". A visiting professional told us, "The care plans are really detailed and the residents are well looked after. It's a fabulous home".

We looked at care records for three people who used the service. The care plans were found to be detailed and gave a good overview of people's needs and the support they required, which meant that people's needs were met and the care was person-centred. The care plans guided the work of care team members and were used as a basis for quality, continuity of care and risk management. The care planning system was found to be a simple system and easy to navigate. We reviewed the 'daily handover sheet', which detailed the staff present at the handover and the handover details regarding the person including an overview of dietary and fluid intake, appointments and visits.

Each care file had a client profile, with a dated photograph of the person which had been taken within the previous six months. Following an initial assessment, care plans were developed detailing the care needs/support, actions and responsibilities, to ensure personalised care was provided to all people. An example for one person stated "intolerance to cow's milk, soya milk to be used". We saw a copy of the general practitioner clinical summary in people's files, which provided an up-to-date summary of the people's current medical history and treatment. The care plans we looked at included a dependency assessment. This information was used by the acting manager to plan staffing levels.

We saw evidence regarding person/family involvement in care planning and the acting manager told us that in future this would be done on an annual basis and would be documented on the 'Service User Review' form. This meant that people were consulted about their care, and the quality and continuity of care was maintained. Care plans were reviewed monthly and on a more regular basis, in line with any changing needs. They were duly signed and dated by a senior member of care staff.

We saw person-centred information had been compiled from discussions with people themselves and their relatives, which meant that staff had an insight into people's needs, preferences, likes, dislikes and interests. We also saw examples of people's preferences in care files for example, "[Name] has her nails done and her hair done and can hold balls and textures of certain items teddy bears"; "Family visits from wife, watching television"; "Family visits and 1:1" and "[Name] likes to go to bed about 10.30pm and get up at 07.00am, has restless behaviour when it becomes dark and has been known to wander, check on 2 hourly throughout night making sure [Name] is safe". We saw evidence that the night check was undertaken and recorded. This meant that staff were able to see the person as an individual and deliver person-centred care that was tailored specifically to the person's needs.

Where people were at risk, there were risk assessments that described the actions staff were to take to reduce the possibility of harm. This meant that risks had been identified and minimised to keep people safe. These included measures to be taken to reduce the risk of falls whilst encouraging people to walk independently. Waterlow risk assessments had been carried out which showed people were at risk of developing pressure ulcers. People's care plans were up-to-date to inform staff about people's care and support needs. We saw an example of a body map for a person which stated "Sore developing, DN to be contacted tomorrow" and we saw evidence of this being actively followed up by staff and documented on the handover sheet. Specialist pressure relieving equipment was in place for example, airflow mattresses and pressure relief cushions. We saw that pressure relief mattresses were checked on a daily basis and adjusted accordingly when people were weighed. This meant that people's care records did contain a detailed care plan to instruct staff what actions they should take to maintain skin integrity and showed that people were receiving inappropriate care and treatment.

We saw records of specialist assessment tools being used in care records for example, Abbey pain scale was used to measure pain in people who were unable to verbalise their pain. Malnutrition universal screening tool (MUST), which is a five-step screening tool, were used to identify if people were malnourished or at risk of malnutrition and were formally reviewed each month. Where people were identified as being at risk of malnutrition, we saw that referrals had been made to the dietician and the speech and language therapist (SALT) for specialist advice, for

Good

Is the service responsive?

example, "[Name] has been assessed by the SALT team and [Name] is on a thick puree diet, kitchen staff are aware, [Name] has assistance from one carer to feed, sits in dining area and doesn't wear dentures". Choking risk assessments were used to identify specific risks associated with people's eating and drinking.

A communication care plan for one person detailed the following "Sits in the communal lounge with other residents to promote stimulation and interaction with others", "Care staff to repeat several times basic instructions as [Name] can find them hard to follow", "Staff to encourage [Name] by talking to [Name] on a one to one basis". The care plan also contained additional information regarding the person, for example, "Hearing good, wears glasses and has diabetic eye screening 6 monthly". The individualised approach to people's needs meant that staff provided flexible and responsive care, recognising that people living with communication impairment could still live a happy and active life.

We found care plans contained information regarding the level of support required to maintain personal hygiene, together with access to the podiatrist and optician. In addition, we saw records, detailing shower and bathing care, for example "[Name] prefers a bath to a shower" and "[Name] is more comfortable without dentures and will refuse them". Care plans included communication records which showed details of appointments with and visits to people in the home by health and social care professionals. This meant that the expertise of appropriate professionals was available to ensure people's healthcare needs were met.

The service employed two activities coordinators. We saw the activities plan on the notice board. This was a daily plan for activities within the home and included bingo, hairdresser, arts and crafts, dominoes, games, quizzes, pub day, 1:1's and manicure. There were also notices displaying the Summer Fayre to be held on 20 June 2015. We observed several residents participating in a game of bingo on the first day of our visit. We saw how staff encouraged participation and supported those people who required assistance. On another day we saw the activities co-ordinator supporting a person to complete a crossword. We saw some people dancing to music in the upstairs lounge. This meant people had access to activities that were important and relevant to them.

People were encouraged and supported to maintain their relationships with their friends and relatives. Relatives and friends could visit at any time of the day. This meant people were protected from social isolation.

We saw a copy of the provider's complaints policy on display in the reception area. The people and the relatives we spoke with were aware of the complaints process. One person told us, "It's alright living here, I have no complaints". We looked at the complaints file and saw the home had received five complaints in the last twelve months. We saw that complaints were recorded, investigated and the complainant informed of the outcome including the details of any action taken. This meant that comments and complaints were listened to and acted on effectively.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post however we had been notified that they were on long term absence. The home was being managed by an acting manager in the interim. A registered manager is a person who has registered with CQC to manage the service. We discussed the management arrangements with the acting manager and the regional manager. We found the arrangements to be satisfactory and supportive of the acting manager.

Staff we spoke with were clear about their role and responsibility. They told us they felt supported in their role and were able to approach the manager or to report concerns. Staff told us, "I like my job", "I am happy. I enjoy everything about my job" and "This is the best home I have worked in".

We looked at what the acting manager did to check the quality of the service. We saw monthly audits were undertaken for care plans, incidents, catering, complaints and medicines. All of these were up to date and included action plans for any identified issues.

We saw that the regional manager undertook monthly quality monitoring visits which audited information about the home for example, accidents, complaints, staffing levels, safeguarding, care files and people's views. We also saw that the home had been awarded a "5 Very Good" Food Hygiene Rating by the Food Standards Agency on 30 October 2014.

We looked at what the acting manager did to seek people's views about the service. We saw residents' meetings were held. We saw records of a residents meeting held on the 1 May 2015. Seven people who used the service attended and discussion items included complaints, meals, medicine and staff. Comments recorded were for example, "no complaints, everything is ok", "No complaints. Staff are very nice and I am quite happy here" and "I am happy with the home, it is nice and clean".

We saw the results of a relatives survey undertaken in January 2015 displayed on notice boards in the home. Fifty questionnaires were distributed and fourteen were completed and returned. The majority of responses received were either "very good" or "good". The questionnaires requested people's views about the service for example, about the staff, catering, housekeeping, laundry and activities. The results were fedback to people at the resident's meeting on 5 February 2015 including the actions taken by the provider. For example some people were unhappy with the menu choices and the provider had revised the four weekly menus. The acting manager also told us she was planning, along with the cook, to have further consultation with people who used the service about the preferred meal options.

Staff meetings were held regularly. We saw a record of a staff meeting dated 6 May 2015. Discussion items included documentation, assistive equipment, meals and menus and the environment. Thirteen staff attended. We also looked at a senior staff meeting record dated 5 May 2015 which discussed care plan audit, staff sickness, medicines management and food and nutrition.

We also saw the provider had undertaken a recent staff survey. Fifteen questionnaires were completed and returned. The responses to the survey were positive and included whether "My supervisor gives me praise and recognition", "Are people accountable for the quality of the work they deliver", "I understand the goals and aims of the company" and "The amount of work I do is reasonable".

This meant that the provider gathered information about the quality of the service from a variety of sources and had systems in place to promote continuous improvement.

We saw a copy of the provider's business continuity management plan dated 1 June 2015. This provided emergency contact details, identified the support people who used the service would require in the event of an evacuation of the premises and contained information about alternative accommodation in the event people needed to be relocated.

The service had policies and procedures in place that took into account guidance and best practice from expert and professional bodies and provided staff with clear instructions. For example, the provider's confidentiality policy refers to the Data Protection Action and the accident reporting policy refers to the Health and Safety Executive and RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations). The acting manager told us, "Policies are regularly discussed during staff supervisions and staff meetings to ensure staff understood and apply them in practice". The staff we spoke with and the records we saw supported this.

Good

Is the service well-led?

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists. This meant the service ensured people's wider healthcare needs were being met through partnership working.