Westward Care Limited

Southlands Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 04 April 2016 and was unannounced. We carried out an inspection in February 2014, where we found the provider was meeting all the regulations we inspected.

Southlands Nursing Home is one of Westward Care Limited home's for older people. The accommodation also includes self-contained apartments. It is located not far from the centre of Leeds, close to local services, bus routes and walking distance of Roundhay Park. It is registered to provide care and accommodation for a maximum of 36 people.

At the time of the inspection, the service had a manager registered with the Care Quality Commission (CQC). 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 told us they felt safe and there were enough staff to keep people safe. We have made a recommendation about the internal door handles. We saw safeguarding training had been arranged for May 2016. People were protected against the risks associated with medicines, however, the registered manager agreed to review the disposal of controlled drugs procedures.

Robust recruitment and selection procedures were in place and staff completed an induction when they started work. Staff training provided did not fully equip staff with the knowledge and skills to support people safely.

People had a good experience at mealtimes and were involved in developing a new menu. People received good support that ensured their health care needs were met. People were able to choose how they wanted the care and support to be delivered, however, the care plans we looked at did not contain decision specific mental capacity assessments in line with the Mental Capacity Act (2005).

People were happy living at the home and felt well cared for. People's care plans contained sufficient and relevant information to provide consistent, person centred care and support. Staff were aware and knew how to respect people's privacy and dignity. However, people's laundry was not always returned to them or in good condition.

There was no opportunity for people to be involved in a range of day to day activities within the home other than when entertainers came into the home. We have made a recommendation about people's wishes and the provider should act on the results of the 'client questionnaire'.

The service had good management and leadership. People got opportunity to comment on the quality of service and influence service delivery. Effective systems were in place that ensured people received safe

quality care. Complaints were welcomed and investigated appropriately.

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.

Staff understood how to keep people safe. We have made a recommendation about the internal door handles. We saw safeguarding training had been arranged for May 2016. Individual risks had been assessed and identified as part of the support and care planning process.

We found that medicines were well managed. However, the registered manager agreed to review the disposal of controlled drugs procedures.

There were enough staff to meet people's needs and the recruitment process was robust.

Is the service effective?

Requires Improvement

The service was not always effective in meeting people's needs.

Staff training provided did not always equip staff with the knowledge and skills to support people safely. Staff completed an induction when they started work.

People were asked to give consent to their care, treatment and support. However, the care plans we looked at did not contain decision specific mental capacity assessments in line with the Mental Capacity Act (2005).

People were supported to have enough to eat and drink and they received appropriate support with their healthcare.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff understood how to treat people with dignity and respect and were confident people received good care. However, people's laundry was not always returned to them or in good condition.

People valued their relationships with the staff team and felt that

they were well cared for.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

We saw the list of entertainers that came into the home but there were no activities available on a day to day basis. We have made a recommendation about people's wishes and the provider should act on the results of the 'client questionnaire'.

People's care plans contained sufficient and relevant information to provide consistent, person centred care and support.

Complaints were responded to appropriately and people were given information on how to make a complaint.

Is the service well-led?

Good

The service was well led.

The manager was supportive and well respected. The provider had systems in place to monitor the quality of the service.

People who used the service, relatives and staff members were asked to comment on the quality of care and support through surveys and meetings.

Southlands 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 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 04 April 2016 and was unannounced. The inspection team consisted of one adult social care inspector, a specialist advisor in nursing and an expert-by-experience who had experience of people living in a nursing environment. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of this inspection there were 26 people living at Southlands Nursing Home. One person was living in the self-contained apartments. We spoke with nine people who used the service, two relatives, six staff, the deputy manager and the registered manager. We spent some time looking at documents and records that related to people's care and support and the management of the service. We looked at three people's care plans.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed all the information we held about the service. This included any statutory notifications that had been sent to us. We contacted the local authority and Healthwatch for feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch stated they had no information about Southlands and the local authority held no current up to date information.

Good

Is the service safe?

Our findings

People we spoke with in general told us they felt safe in the home and did not have any concerns. One person told us, "Mostly. I am not terribly sure; when it's dark. There is always a light out there." Another person told us, "I feel safe but there are only two or three staff on at night; there could be more."

We found staffing levels were sufficient to meet the needs of people who used the service. The registered manager told us the staffing levels agreed within the home were being complied with, and this included the skill mix of staff. The registered manager showed us the staff duty rotas and explained how staff were allocated on each shift. They said where there was a shortfall, for example, when staff were off sick or on leave, existing staff worked additional hours or agency staff were requested. They said this ensured there was continuity in service and maintained the care, support and welfare needs of the people living in the home.

Staff we spoke with told us there were in general enough staff on each shift. One staff member told us, "At this time we have enough staff." Another staff member told us, "Generally there are enough staff. They are recruiting new staff but we have very good agency staff when needed." However, one staff member told us, "Staffing is very poor because they rely on agency a lot. Some agency staff are the same but some are not. They are slowly recruiting more."

The PIR stated 'As part of our refurbishment and development programme a new nurse call bell system has been introduced which will enable a report of all assistance requested and times taken to receive care. We saw people did not have to wait long for their call bell to be answered by a staff member. The people who lived at the home generally felt there were sufficient staff to provide the care services that were required. One person told us, "Yes, I use the buzzer, but it's not with me now." We asked how they would attract attention and they pointed to the buzzer on the wall, which was out of their reach. The registered manager told us the call bell was portable and was sat on a small table in the room which people were able to access to call for assistance. Other comments included, "Sometimes they answer the buzzer straight away, but not always", "Yes, they come. The buzzer is very effective; you don't have to wait long", "Not a long wait for the buzzer to be answered" and "There are a lot of them. I only have to whistle and someone comes. I'm rarely left stranded." One person told us agency staff were used on occasion. They said, "Some. I can't understand what they are saying. Some don't say very much. Some you see then you don't see them for about three weeks."

We observed people being moved safely using a mechanical hoist throughout the day. We saw people were supported safely to stand and assisted to walk, staff explained what they were doing and this was done with patience. The hoists we saw had been serviced recently.

We saw people had personal emergency evacuation plans which identified individual moving and handling needs should the building need to be evacuated in an emergency. We saw there were several health and safety checks carried out, for example, room safety, window restrictors and bed rails. The registered manager told us there were systems in place to ensure the home was maintained in good order and

electrical and water safety and temperatures were undertaken and recorded.

We reviewed the recruitment and selection process and found appropriate checks had been made to establish the suitability of each candidate. We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. These included a disclosure and barring service check (DBS). The DBS is a national agency that holds information about people. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.

We spoke with members of staff about their understanding of how to keep people safe. For example one staff member told us, "I would report if the hoist was not working or if there were wires sticking out. Staff told us they would report any incident to the registered manager.

Some staff we spoke to told us they had received safeguarding training. However, one staff member told us they had not received safeguarding training. In addition to this, staff training records we saw stated 23 staff out of 43 had completed safeguarding training but other staff had still yet to complete the training. The registered manager told us they had recruited a lot of new staff and further training had been booked. The staff induction programme included awareness of safeguarding and what should be reported. We did see further safeguarding training had been booked for May 2016. Following our inspection the provider told us 35 out of 43 staff had received in date safeguarding awareness training. The remainder of the staff have all received safeguarding training and had been booked on course to attend a refresher course.

The service had policies and procedures for safeguarding vulnerable adults and we saw the safeguarding policies were available and accessible to members of staff. Staff we spoke with said they were aware of the services whistle blowing policy and would not hesitate to use it.

Care plans we looked at showed people had risks assessed appropriately and these were updated regularly and where necessary revised. We saw risk assessments had been carried out to cover activities and health and safety issues. These included nutritional risks, falls, moving and handling, bed rails, pressure care and mouth care assessments. These identified hazards that people might face and provided guidance about what action staff needed to take in order to reduce or eliminate the risk of harm. This helped ensure people were supported to take responsible risks as part of their daily lifestyle with the minimum necessary restrictions.

We saw the home's fire risk assessment and records, which showed fire safety equipment was tested and fire evacuation procedures were practiced. We noted the fire procedure was displayed in the entrance to the home. One staff member told us, "The fire alarms are checked weekly on a Thursday and we have six fire drills a year."

We saw two of the internal doors had two handles fitted, one pushed downwards and one pushed outwards so did not operate in the way people would expect. They were used to keep people safe but they also restricted people's freedom. There were others doors which could be used as an exit route in the event of a fire. The registered manager told us the handles had been there a long time, would review the reasons behind this and would have the handles removed.

We recommend the provider considers reviewing the use of internal door handles where one handle pushed downwards and one handle pushed outwards.

We saw the medication room was clean and had sufficient working surfaces; the temperature was controlled

with air conditioning. All cupboards were locked, as were the medication trolleys. The fridge temperature was checked regularly. There was a folder for medication that was to be returned to pharmacy, and there were appropriate disposal bins for the medicines. We checked random medicines and found they were in date.

For recording the administration of medicines, medicine administration records (MARs) were used. Each person's MAR folder had a specimen signature at the front. There was a photograph of each person and these were clear and a true reflection. Allergy information was clearly recorded. The MAR's were completed appropriately and when a person had a medication omitted there was a clear reason recorded.

Each person had a 'medication support plan' with their MAR. This explained what support the person required. For example, We saw one person's medication support plan clearly demonstrated their required support about the administration of medication and this was clearly written for staff to follow.

We observed a medication round. This was by two nurses, as one of the nurses was on induction and being supervised. We saw one of the medicines given, was dispensed by one of the nurses who asked the other nurse to administer it as they didn't know the person well enough. This doesn't comply with best practice guidance. The dispensing nurse should be administering and signing the MAR.

We saw time critical medication, for example, medicine for Parkinson's' disease was given at the correct time. We saw one person was prescribed a transdermal patch. This was applied to different areas of the body and the rotation was displayed on a body map in the care plan.

Checks of the Controlled Drugs (CD's) were satisfactory, with clear recordings which corresponded to drugs held. The CD's were disposed of on-site once they were no longer required. The home used a process called 'denaturing kit' to dispose of medicine out of an ampoule. For example, if the medication is 5mls and only require 2.5mls was used the remainder 2.5mls would be disposed of using the denaturing kit. The nurse confirmed this was the process used which, included patches, tablets and ampoules. The provider's policy was not clear of how CD's should be disposed.

We saw a 'medication administration audit' folder. The audit was completed each day by the night staff. There were medication competency assessments carried out for staff administrating medicines.

The PIR stated 'Newly refurbished bedrooms have en suite facilities. A new dining and care lounge will ensure residents have a choice for areas of relaxation'. We saw people enjoying the new lounge facilities.

Requires Improvement

Is the service effective?

Our findings

We looked at staff training records, which showed staff had completed a range of training sessions. These included fire training, first aid, health and safety and infection control. Staff we spoke with told us they had completed training in infection control, palliative care, customer care and moving and handling. However, we saw from the training records some training for staff had expired. For example, equality and diversity training was required to be completed every three years, three staff members had last completed this training in May and June 2012. We did see some staff members training had been booked but no date was given of when this was going to take place. One staff member said, "I am happy with the training and it supports me in my role." The registered manager told us the training record required updating and would be addressing this immediately.

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. We saw from the staff records we looked at that supervision had not been carried out routinely. The staff supervision records showed two staff members had received supervision four times since 2014. One staff member told us they had not had supervision in the last six months. Another staff member told us, "This is every three months but I think my last one was last year." A third staff member told us, "Supervision is once every two months." Staff members told us they had received an appraisal in 2015 and this was confirmed by the registered manager. The home's supervision policy stated 'supervisions will be a formal arrangement either individually or by group sessions, this will give all care staff an opportunity to discuss their work with an experienced line manager', however, the policy did not state how often supervision should take place. The registered manager told us the supervision programme needed further work and development and they would be addressing this.

We were told by the registered manager staff completed an induction programme which included orientation of the home, policies and procedure and training. We looked at staff files and were able to see information relating to the completion of induction.

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.

During our visit we observed staff gaining permission from people before they performed any personal care or intervention. Some staff we spoke with said they had received training and other staff said they had not. The training records showed most staff had completed Mental Capacity Act (2005) training and some further training had been booked for staff to attend.

We saw evidence in the care plans people or their relatives had given consent to releasing information to relevant care agencies and also to a photograph. The care plans we looked at had mental capacity

assessments however, these were not decision specific. One person's care plan stated if there was no capacity the decision should be documented on the GP record but there was not further information recorded on the GP record. We saw there was a 'best interest's decision' for the safe use of bedrails and a form that stated the person's family member had 'was to be able to make healthcare decisions'. There was no power of attorney information available. The registered manager told us they would review this process and what information was recorded.

People we spoke with told us generally the food was nice. One person told us, "It's basic. "It's very good, there are choices. You can make suggestions and they might appear a few days later." Another person said, "It's very good, the food is pretty good. It could do with more variety. Its good stuff well produced." One person said, "Oh, yes but they can't cook veg to save their lives. It's too hard." Other comments included, "I think its poor." we asked why they thought that and they replied, "The vegetables are in my opinion, undercooked." "We do get choices; some of them I don't like but often you can have something else instead. I can have breakfast in bed" and "The vegetables are never cooked properly and the meat is tough. My daughter is raising this with the manager. The salmon is nice. If the food is as nice as it sounds it'll be alright."

One staff member told us, "Food is poor. Meals are fancy and residents don't like fancy food." Another staff member told us, "They are trying to introduce new foods and people have choice. The meal experience is ok." A third staff member said, "It has gone too fancy. One resident said they don't want it because they cannot pronounce it. People can have different things if they want."

We spoke with the chef who told us they always had enough food and fresh vegetables and alternative meals were available if people did not want what was on the menu. They said people were involved in the menu and the menu was explained to them. They said, "It is a nice experience for people." We saw a lunch and teatime menu was displayed on the tables in the dining rooms. The lunchtime menu included chicken leg cooked in creamy mushroom sauce, savoury veggie mince with Yorkshire pudding or beetroot gravlax with honey and mustard sauce and mixed salad. The registered manager told us they had carried out a 'my favourite meal' survey with people who used the service, as a result a new menu was to be introduced.

We saw people were able to choose where they wanted to have their meals. We saw the dining rooms were pleasant with a calm atmosphere. The tables in the dining room were set with tablecloths, cutlery, glasses and paper napkins. We observed the lunch time meal. The food looked quite appetising and the chef popped in to see people several times during lunch. Staff were responsive to people's needs and choices were offered. We saw staff assisting one person to eat their meal but didn't talk to the person they were helping. People did not have to wait long for service.

We saw during the morning people had access to drinks, snacks and fresh fruit. We also noted the chef was aware of people's dietary needs. For example, they knew how many people living in the home were diabetic.

We saw evidence in the care plans; people received support and services from a range of external healthcare professionals. For example; one person had an appointment with the optician and one person was seen by the wound prevention in February 2016. We saw when professionals visited, this was recorded and care plans were changed accordingly.

One person we spoke when we asked if they saw the dentist said, "It's a good while since, and I haven't been for a long time. I suppose it would make me eat better." We spoke with the registered manager about this who said they would speak with the person. Following the inspection the registered manager told us the person had only been recently admitted to the home and an appropriate referral had been made for them

to receive a dental review. Staff we spoke with said, "The optician comes to the home and most people have a private dentist." Another staff member said, "People see the GP, optician, dentist and chiropodist."

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they liked the staff and felt comfortable with them and were happy living at Southlands Nursing Home. One person said, "Yes, staff are caring. They are all very caring and thoughtful." We asked if they had a key worker who cared for them and they said, "Yes but I don't know her name." The key worker system is where a staff member ensures a person's personal care and effects were appropriate and in order and liaised with their relatives and health professionals when needed. Another person told us, "They cut up my food. It's not too bad. I didn't like it but I've settled. I suppose I do feel well cared for. There are nurses who wash and dress me because I've gone to pieces."

We observed staff spoke with people in a caring way and supported their needs. We saw staff responded to people swiftly and respectfully when they asked for support. We observed the interactions between staff and people were unhurried, friendly and sensitive. Staff knew people well. We observed a number of transfers by hoist, and these were done with staff, talking to the person throughout. We saw people looked well dressed.

One staff member we spoke with said, "Care is brilliant, residents are well looked after." Another staff member said, "Care is good and people are well looked after. I am here for the residents." A third staff member said, "I am a stickler for making sure people are well looked after and I help people to choose what they want to wear."

Relatives were coming and going throughout the day without restriction. We saw people were able to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. The premises were fairly spacious and allowed people to spend time on their own if they wished.

Throughout the day we observed staff knocked on the doors of people before entering their bedroom and made sure people's clothing was appropriate when they were been hoisted. One staff member said, "Dignity is respected." Another staff member said, "We always knock on people's doors." A third staff member said, "I make sure the doors are closed and people are covered when washing." One person when asked if they felt they were treated with dignity said, "Not always; most of its ok." Our observations throughout the inspection confirmed staff treated people with dignity and respect when carrying out day to day support.

We asked people about the laundry service. One person when asked if they got their own clothes back said, "Yes but occasionally you get somebody else's." Another person said, "I recognise them but they keep shrinking my clothes." We asked if they had complained and they said yes but did not have an outcome. A third person said, "It's sometimes a disaster. They washed my trousers and they shrunk in the dryer. These are not my socks and this is not my cardigan." The person's relative agreed the items they were wearing were not theirs. They said the manager had not offered to compensate as yet but was sure they would. Provider told us they were responsive to people's complaints about their laundry and would compensate for any accidents.

A relative we spoke with said, "No I am not happy with the laundry service, he doesn't always get his clothes

back, he is getting other people's clothes. This is a special rug and they have washed it, put it in the drier and shrunk it and it has gone hard. It should be dry cleaned and I put a notice here [on the wardrobe door] about his laundry. There are knitted sweaters here that [name of family member] knitted for him and I want him to have them here. These items mean a lot." We concluded this did not respect people's dignity. We looked at 12 recently returned resident and relative survey's which showed seven people said the laundry service was poor and one person said it was fair.

The registered manager told us they had appointed two new housekeeping staff , one staff member started last week and one staff member was due to start next week. They said each staff member will be allocated specific rooms and will take responsibility for the person's clothing and laundry. Part of the role will include checking people get their own clothes back from the laundry and labelling items of clothing if needed.

Requires Improvement

Is the service responsive?

Our findings

We saw people spending time in their rooms or in the lounge areas. One person was reading a newspaper. We saw the list of entertainers that came into the home which, included music for health, music and entertainment and a person who did reminiscence. We did not see a list of activities that were available on a day to day basis and we did not see any activities taking place on the day of our inspection. This meant other than one person reading a newspaper and the television been on in the lounge area, no other activities were on offer for people. We asked the manager what activities there were on day to day basis. The registered manager told us the home was in the process of employing an activity co-ordinator. They said as a consequence of opening another part of the building this had impacted on activities, staff who used to do activities were now carrying out care duties. The meant the service did not have a dedicated member of staff who was responsible for activities for people.

People we spoke with told us, "Oh yes, we have reminiscence days. She is very good. She comes about once a month. Someone comes with a guitar and we have a children's choir and there is always a Christmas show." "Yes, I never get bored but we have had a couple of entertainers; they were good." "Oh, last week we went down and a man came who played his guitar. He played all sorts of old songs. I haven't done anything else." "Usually about once a week we have a planned activity." "Occasionally, very occasionally someone will sit with me." "Less and less so now they are so busy. The vicar comes once a month but he is off sick now."

One relative told us, "There are sitting exercises fortnightly and sing songs in the afternoon."

However, we noted from the 'client questionnaire' summary for April 2015 a response from the registered manager stating 'activities co-ordinator to be appointed and a wider range of activities and one to one time to be introduced'. The registered manager told us these actions were still on-going. One staff member said, "The home provides activities but I don't know what kind because they don't come when I'm here."

The PIR stated 'we plan to re-introduce volunteers to our service to involve our residents in the wider community and to reflect this is our programme of activities'.

We recommend the provider determines what people's individual interests are and what activities they like to take part in and act on the client questionnaire dated April 2015.

People had their needs assessed before they moved into the home. Information was gathered from a variety of sources, for example, any information the person could provide, their families and friends, and any health and social care professional involved in their life. This helped to ensure the assessments were detailed and covered all elements of the person's life and ensured the home was able to meet the needs of people they were planning to admit to the home. The information was then used to complete a more detailed care plan which provided staff with the information to deliver appropriate care.

People's care plans were person centred and reflected the needs and support people required. They

included information about their personal preferences and were focused on how staff should support individual people to meet their needs. We saw there was a; 'portrait of my life' which included details of people's 'childhood', 'my working life', 'significant relationships', 'significant places', 'social activities and interests', 'significant life events', 'my life now and people who are important to me now'. One staff member said, "The care plans are good and updated." Another staff member said, "Care plans are up to date and everything is in there."

We saw evidence of care plans being reviewed regularly and the reviews included all of the relevant people. The care plans were appropriate for each person. One person's care plan stated they were underweight and at 'high risk' on their nutritional assessment. The care plan stated they were on a fortified diet and were reviewed weekly. Another person care plan stated they had type II diabetes and we say their blood sugar levels were checked on a weekly basis as the person's blood sugar level was currently stable. We saw one person was appropriately referred to the tissue viability nurse following concerns with the person's skin integrity.

We noted that two people's pressure relieving mattresses were set at different pressures although the two people weighed more or less the same. The registered manager told us they would address this immediately and instigate regular check for mattress settings.

We asked people and/or their relatives if they had been involved in decisions and choices about their care including care planning. One person said, "No." Another person said, "I've never been asked." A third person said, "I feel confident about it; we had a meeting." A relative told us, "No but on the whole we are very pleased." The registered manager told us the care plans were reviewed every six months with the person and/or family members. Following the inspection the provider stated, 'although some people who use the service and their relatives could not recall being involved with the care planning and decisions and choices of care plans, the provider was able to evidence that all people and/or their families had been involved and had signed the care plans to evidence their agreement to the plan of care'.

People told us they would speak with staff if they had any concerns and they did not have any problem doing that. They said they felt confident that the staff would listen and act on their concern. The registered manager told us people were given support to make a comment or complaint where they needed assistance. Staff we spoke with knew how to respond to complaints and understood the complaints procedure.

We looked at the complaints records and saw there was a clear procedure that had been followed when complaints had been investigated. For example, we looked at one person's complaint dated 07 December 2015 and this had been responded to by 16 December 2015 with a satisfactory outcome.

We noted one relative was upset about their family member's care and treatment. They told us they thought the communication was poor with staff and they said, "The manager has said there are other people she has to deal with. If someone would just spend ten minutes a day updating me." The registered manager told us this was being managed through the homes formal complaints procedure and meetings with the family member.

We saw some compliments had been sent to the home. These included, 'Just a little note to say thank you for the support' and 'Just wanted to thank each and every one of you for making my granny's last few months so comfortable'. Following our inspection the registered manager told us the home had received four complaints in the previous 12 months and there were 19 recorded compliments.

Good

Is the service well-led?

Our findings

At the time of our inspection the service did have a registered manager. The registered manager worked alongside staff overseeing the care and support given and providing support and guidance where needed. They told us they had recently employed a new deputy manager who started at the home at the beginning of April 2016.

Staff we spoke with told us the manager was good and they had confidence in them. One staff member said, "The manager listens and I can go to her with anything. The home is managed ok." Another staff member said, "[Name of manager] is good, I get on well with her. She has altered some things for the better. She listens, is supportive and encourages you to do well. I am really happy. I love coming to work, it is a nice atmosphere and staff are nice." However, one staff member said, "There is no structure. I don't think it is run properly."

One person we spoke with told us, "Yes, [name of manager] seems to be on the ball." A relative said, "Yes, [name of manager] is very good. I have found it satisfactory."

We asked people if there would be anything they would change about the service. One person said, "We are separated. We have been married for many years. We are here as a pair but we are not acting as a pair. Our rooms are too far apart and we would like them to be closer." Following the inspection the registered manager told us they have been exploring all available options with the people who used the service and their family members to meet their preferences.

The registered manager told us they monitored the quality of the service. We saw daily, weekly and monthly checks were carried out which, included wheelchairs, dining rooms, stock cupboards, medical equipment and wound evaluations. We noted the senior care staff checked areas of the home and any actions that needed to be completed were recorded. We saw the home reviewed different areas on an annual basis which, included person centred care, dignity and respect, safety, complaints, staffing and food and drink. We saw a health and safety audit dated November 2015 had been completed, an action plan was in place and we saw action were been addressed. The registered manager completed a weekly report which included occupancy levels, vacancies, complaints, staffing and maintenance issues. This was last completed on 27 March 2016.

We were told by the registered manger staff meetings were held on a six monthly basis. We looked at the meeting minutes dated January 2016. These included discussions about new staff, dining experience, maintenance, furnishings and housekeeping.

We saw a resident and relative's survey had recently been sent out. The registered manager told us they were still in the process of analysing this information. We saw the survey's showed very positive comments in some areas which included care, accommodation and housekeeping. However, other areas were not as positive, for example, catering and laundry. Newsletters were produced by the home bi monthly which, gave people information about staffing, new residents and entertainers that would be coming to the home.

Records showed the registered manager had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence. Staff we spoke with said they knew what to do in the event of an accident or an incident and the procedure for reporting and recording any occurrences.

The PIR stated 'The head of catering will introduce a daily comment book on the quality of the new menus and will adapt and make changes in response to these views. We also plan to enlist the support of a group quality and compliance manager to ensure all auditing processes are robust and timely'.