Mrs Sarah Jane Slack & Mr David Michael Slack

Prospect House Residential Home

Inspection report

Low Street
Swinefleet
Goole
East Yorkshire
DN14 8DF
Tel: 01405 704259
Website: www.prospecthouse.me.uk

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Ratings

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

Overall summary

This inspection took place on 6 January 2016 and was unannounced. We previously visited the service on 18 December 2013 and we found that the registered provider met the regulations we assessed.

The service is registered to provide accommodation for up to 24 people who require assistance with personal care, some of whom may be living with dementia. The home is situated in Swinefleet, a village close to the town of Goole, in the East Riding of Yorkshire. The property is on the main road in the centre of the village and there is a small car park to the front of the premises.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was registered with the Care

Summary of findings

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.

At this inspection we found that the service was safe. People's needs were assessed and comprehensive risk assessments put in place to reduce the risk of avoidable harm. Staff had received training on safeguarding adults from abuse and understood their responsibilities in respect of reporting any concerns.

Staff who had responsibility for the administration of medication had completed appropriate training. Medicines were administered safely by staff and the arrangements for storage and recording were robust.

People were supported to make decisions and their rights were protected in line with relevant legislation and guidance.

The service had an effective recruitment process and this ensured only people considered suitable to work with vulnerable people had been employed. We saw that there were sufficient numbers of staff employed to meet the needs of people who lived at the home.

Staff told us they were happy with the training provided for them, and we saw that there were effective induction training and refresher training programmes in place.

People were supported to access healthcare services. We saw that advice and guidance from healthcare professionals was incorporated into care plans to ensure that staff provided effective care and support. People's nutritional needs were met; their likes, dislikes and special diets were known by staff and were catered for.

People using the service were positive about the caring attitudes of staff. We observed that staff were kind, caring and attentive to people's needs and that they respected people's privacy and dignity. Staff encouraged people to make decisions and have choice and control over their daily routines.

We saw that there were systems in place to assess and record people's needs so that staff could provide personalised care and support. Care plans were updated regularly and information shared so that staff were aware of people's changing needs.

People told us they were able to make comments, complaints or raise concerns although they had not needed to.

The manager was proactive in monitoring the quality of care and support provided and in driving improvements within the service. There was clear organisation and leadership with good communication between the registered provider, registered manager and staff. We observed that records were well maintained.

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.

People's needs were assessed and risk assessments put in place to reduce the risk of harm.

There was a safe recruitment process in place to ensure only people considered suitable to work with vulnerable people had been employed. There were sufficient numbers of staff employed to meet people's needs.

People were protected against the risks associated with the use and management of medicines. People received their medicines at the times they needed them and in a safe way.

Good

Is the service effective?
The service was effective.

We found the registered manager understood how to meet the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff undertook training that equipped them with the skills they needed to carry out their roles.

People's nutritional needs were assessed and met, and people told us they were happy with the meals provided by the home.

Good

Is the service caring?
The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people and staff on the day of the inspection.

People's individual care needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Good

Is the service responsive?
The service was responsive to people's needs.

People's care plans recorded information about their previous lifestyle and their preferences and wishes for care and support.

Visitors were made welcome at the home and people were encouraged to take part in suitable activities.

People told us that they had no concerns or complaints but they would not hesitate to speak to the registered manager if they had any concerns.

Good

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

Good

Summary of findings

There was a registered manager in post and there was evidence that the home was well managed.

There were sufficient opportunities for people who lived at the home, staff and relatives to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe care and that the premises provided a safe environment for people who lived and worked at the home.

Prospect House Residential 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.

The inspection took place on 6 January 2016 and was unannounced. The inspection was carried out by one adult social care inspector and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who has used this type of service. The expert by experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authority who commissioned a service from the home. The registered provider submitted a provider information return [PIR] prior to the inspection. 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.

On the day of the inspection we spoke with six people who lived at the home, three visitors, the registered provider, the registered manager, the deputy manager and three members of staff. Following the day of the inspection we received feedback from a social care professional and a health care professional.

We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the service, including staff training and quality monitoring records.

Good

Is the service safe?

Our findings

We asked people if they felt safe living at the home and they confirmed that they did. One person said, "Yes, there's people about and there's a call button" and another told us "Yes, the area, stairs, building – all good." This view was supported by the relatives who we spoke with. Comments included, "Yes, she has got 24 hour care, I feel she is safe here" and "Yes, I feel they keep an eye on her." We asked staff how they kept people safe and comments included, "Follow policies and procedures, our training and by following health and safety rules" and "Through our moving and handling training."

Care plans recorded assessments and risk assessments in respect of diet and nutrition, mobility / falls, skin / pressure area care and infection control. Some people had assessments in place for risks that were more specific to them, such as diabetes, 'negative' thoughts, and the use of bed rails. Risk assessments were scored to identify the level of risk involved. All risk assessments were recorded under the headings "Hazard, who might be harmed, evaluate the risk and further steps to ensure the risk is reasonably controlled." This showed that any identified risks had been considered and that measures had been put in place to attempt to manage them. We noted that one person had Steredent in their bedroom; we discussed with the registered manager how this product should be stored safely so it could not be taken by anyone else who lived at the home and that there needed to be a risk assessment in place.

We saw staff assisting people to mobilise on the day of the inspection and noted that these manoeuvres were carried out safely. Care plans in respect of mobility described safe use of the hoist, which sling should be used and how many staff were needed to carry out moving and handling safely.

Records we saw showed that staff had completed training on safeguarding adults from abuse. The staff who we spoke with were able to describe different types of abuse, and they told us that they would report any incidents or concerns to the registered manager. They said they were confident that the registered manager would take appropriate action and ensure issues were dealt with in line with the home's policies and procedures. One member of staff said that they would take action if they saw poor practice by a colleague. They said, "I would intervene, take the person to the office, write a report and contact [The manager]." We saw that any safeguarding alerts were stored in a folder along with CQC notifications and a record of accidents / incidents, and the records we saw showed that the CQC had been notified appropriately of any safeguarding incidents.

We contacted the local safeguarding adult's team prior to the inspection. They told us that they had not received any concerns about the home during the previous year. The CQC had received one notification from the registered manager in respect of an incident that had occurred and we noted that this had been dealt with professionally and following the home's policy and procedure.

A social care professional told us they had arranged for someone to have respite care at Prospect House. Their condition had deteriorated and they began to display behaviour that could put themselves and others at risk. The social care professional told us that the registered manager took prompt action to contact health care professionals to seek advice and that staff continued to support this person and interact with them effectively. Staff at the home made every effort to meet this person's needs and kept their family informed throughout.

Staff told us that they would not hesitate to use the home's whistle blowing policy if needed, and that they were certain their confidentiality would be respected. One member of staff said, "I feel comfortable approaching [The manager] and I know it would be dealt with."

There was a recruitment policy and procedure in place. We checked the recruitment records for two members of staff. We saw that an application form had been completed, references obtained and checks made with the Disclosure and Barring Service [DBS]. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. We saw that this information had been received prior to the new employees starting work at the home. This meant that only people considered suitable to work with vulnerable people had been employed. We saw that a record of interview questions and responses had been retained for future reference. Staff were provided with job descriptions; this ensured staff were aware of what was expected of them.

Good

Is the service safe?

Staff described the usual staffing levels to us; these were three care workers and a senior care worker in a morning, two care workers and a senior care worker in the afternoon / evenings and one care worker and one senior care worker overnight. The registered manager was on duty in addition to these members of staff. We checked the staff rotas for a two week period and saw that these staffing levels had been maintained. Staff told us that they felt there were sufficient numbers of staff on duty to meet people's needs. They also said that they did not use agency staff as there was always a member of staff who would cover absences. One member of staff said, "Staffing levels are fine – staff are really good here."

People who lived at the home told us that there were sufficient members of staff to meet their needs. They said that staff answered call bells promptly. One person said, "Yes, I have a buzzer and they come – enough staff around" and another told us "Yes, I have always been satisfied." Two relatives told us there were sufficient numbers of staff; one person said, "I think so – always somebody around" and another told us, "Yes, I usually find staff." Another person said they sometimes felt they needed more staff but added, "But I have no anxieties about it." We saw that there were sufficient numbers of staff on duty to meet the needs of people who currently lived at the home.

We checked maintenance records and saw that there were up to date service certificates in place for the fire alarm system, fire extinguishers, emergency lighting, gas appliances and boilers, electrical installations, portable appliances and lifts / hoists. In addition to this, in-house checks were being carried out to make sure equipment was properly maintained and safe for use. These included checks on bed rails and water temperatures. We saw that windows had opening restrictors in place. The registered provider told us that these were checked on a regular basis but these checks were currently not being recorded. They told us they would record these checks in future. This meant that the premises were being maintained in a safe condition.

We checked the accident / incident / notification book and noted that accidents and incidents had been recorded appropriately. Accident reports recorded the name of the person concerned, the nature of the accident or incident, who was injured, whether medical advice was required, whether the next of kin was informed and whether the accident had needed to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations [RIDDOR]. We saw that some accident records were accompanied by body maps; this helped staff to manage the person's recovery. We saw that the recording on accident forms was very thorough and that the registered manager checked every accident form. This allowed the registered manager to monitor accident forms for areas that night require improvement.

Medicines were stored in a medication trolley and the trolley was stored in the medication cupboard. The medication cupboard door was kept locked at all times. Records evidenced that products for external and internal use were stored separately, as recommended. The temperature of the medication fridge and medication room were monitored regularly and recorded. This evidenced that medicines were stored securely and at the correct temperature.

Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The packs were colour coded to indicate the time of day the medicines needed to be administered. We checked a sample of medication administration record [MAR] charts and saw that they included a photograph of the person concerned to aid recognition for new staff, and details of any allergies. We saw that codes were being used appropriately to record when people had refused their medication, that two staff had signed hand written records to show they had been double-checked and that there were no gaps in recording. We saw that medication systems were audited both weekly and monthly. The checks monitored storage [including for those people who self-medicated] and recording on MAR charts.

There were specific instructions for people who had been prescribed Warfarin; people who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered. These records had also been audited each month to check that people's Warfarin medication had been administered correctly.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs [CDs] and there are strict legal controls to govern how they are prescribed, stored and administered. We checked the storage of CDs and noted they were stored securely. We checked a sample of medicines held against

Good

Is the service safe?

CD records and saw that the stock of medicines held matched the records in the CD book. Two staff had signed the CD book to record when medication had been administered.

There was an audit trail to evidence that medication that had been prescribed by the GP was the same as the medication delivered by the pharmacy. There were satisfactory arrangements in place for the disposal of unwanted or unused medication.

We saw that creams were kept in people's bedrooms. Staff told us that they did not receive topical charts from the pharmacy to identify where creams needed to be applied but that they would now request them. We discussed that creams needed to be stored safely to ensure they could not be accidentally ingested by people who lived at the home, and staff assured us that this would be addressed.

Records showed that senior staff who had responsibility for the administration of medication had completed training, and this was confirmed by the staff who we spoke with. Care workers confirmed that only senior staff were responsible for administering medication.

We saw the registered provider's business contingency plan; this was held within the fire evacuation book in the front entrance of the home. The plan advised staff on the action to take in the event of a fire, power failures and other emergency situations, and included the telephone numbers for staff, GP surgeries, relatives and the assistance people would need to evacuate the premises. In people's individual care plans we that there were also fire evacuation plans in place. These recorded the assistance a person would need to evacuate the premises in an emergency, including support from staff and any equipment they would need to use.

We noted that the premises were clean throughout and that there were no unpleasant odours in either communal or private areas of the home.

Good

Is the service effective?

Our findings

People who lived at the home told us that staff had the right skills to do the job and this was supported by the relatives we spoke with. One relative commented, "She likes it here – they always have a lot of banter with her."

We saw the details of the home's induction programme and noted it recorded the training that would be completed from day one up to week twelve. Staff told us that they completed training on fire safety, accident / incident procedures, moving and handling, medication, first aid and health and safety. Staff were given a copy of the staff handbook during their induction period and the registered manager discussed National Vocational Qualification [NVQ] training with them. One person told us that they had worked alongside a senior care worker for the first three months of their employment, and another told us they had shadowed experienced staff as part of their induction training. We discussed with the registered manager how it would be helpful to have clearer records of the topics staff covered during induction training and they agreed to address this.

Staff told us they had attended a variety of training courses during the last year, including mental health awareness, team leading, first aid, fire safety, safeguarding vulnerable adults from abuse and dementia awareness, and some staff said they had commenced a National Vocational Qualification [NVQ]. A senior care worker was undertaking this award at Level 5 and another care worker told us they had just completed this award at Level 3. This showed us that the registered provider supported staff to keep their skills and knowledge up to date and to undertake formal qualifications.

We saw that each member of staff had a 'staff supervision and performance' form in place. This recorded all training that they had undertaken and the date it had been completed. We saw that some of the training listed included palliative care, health and safety, mental health awareness, infection control for managers and fire safety. The proposed training list for 2016 included training courses on fire safety, diabetes and medication and we saw a record stating that two staff had applied for the courses on diabetes and medication; these courses were being provided by the local authority.

The service also used a private training company to provide e-learning for staff; the topics they covered were health and safety, death, dying and bereavement and the Mental Capacity Act 2005 [MCA]. Staff were required to read and complete work books, and return them to the registered manager by a set date. The registered manager used a 'staff progress chart' to monitor how staff were progressing with this training. When completed, they were sent to the private training company for assessment. St. John's Ambulance provided first aid training for staff at the home; the most recent course was on 30 November 2015 and we saw that 18 staff attended.

Staff told us that they had supervision meetings with the registered manager or deputy manager on a regular basis. These are meetings where staff can discuss their performance and any concerns they might have with a manager. However, staff said that they would not wait for supervision meetings to discuss any concerns as the registered manager had an 'open door' policy and they could speak with them at any time. In addition to supervision meetings, we saw that the registered manager advertised 'staff support sessions'. These were times they put aside to see any member of staff who needed to see them. Staff could enter their name on the list in a particular timeslot, or if they wished the meeting to remain confidential, they could speak to the manager in private to 'book' a slot. The registered manager told us that they had introduced these sessions so that staff knew they could speak to her when they needed to, and did not have to wait until their next formal supervision meeting.

A health care professional told us that staff at the home asked for advice appropriately, that they listened and then followed the advice they were given. They said, "Staff are quick to highlight any issues."We saw that any contact with health care professionals was recorded; this included the reason for the contact and the outcome. People told us that they could see their GP or a district nurse when they needed to. Comments included, "They would call one straight away, and I have seen a district nurse" and "If I wasn't very well they would call the GP." A social care professional told us that staff had acted quickly in informing a person's GP when they refused to take their prescribed medication. A relative told us that they were always informed about any health care concerns or contact with the GP in respect of their family member. Staff told us

they would not hesitate to ring a person's GP if they were unwell. Records we saw evidenced that health care professionals such as speech and language therapy [SALT] services were involved appropriately in people's care.

Relatives told us they were happy with the level of communication between themselves and staff at the home. They said that they were kept informed of any events involving their family member including the outcome of hospital appointments. We saw there was a record in each person's care plan where contact with their relative was listed. One relative said, "They ring up whenever they need to."

We saw that there were risk assessments in place to advise staff how to manage any identified risks, such as the risk of malnutrition, choking or coughing. Staff told us that people's special dietary requirements were recorded in their care plans, such as, "[Name] is diabetic which is treated with medication and a low sugar diet." They were able to describe people's special diets to us, such as "Textured C" and "Textured D" diets. They said that they took advice from dieticians and SALT when they had concerns about a person's nutritional intake. We saw in one person's care plan, "Assessed by SALT as needing texture D pre-mash diet due to coughing when eating. Needs to be in an upright position." This person's care plan recorded that the risk level had moved to 'low' since the assessment undertaken by SALT and the new arrangements had been put in place. Three of the people who we spoke with told us they had diabetes and that their special nutritional needs were met.

Staff told us they monitored a person's dietary intake on food and fluid charts when this had been identified as an area of concern, as well as on 'Daily Living' charts. People were also weighed as part of nutritional screening.

Care plans recorded people's dietary likes and dislikes. People told us that they enjoyed the meals at the home and that they were offered a variety of choices. One person said, "[The meals] are good. They ask in a morning and we have a choice at lunch" and another told us, "Good – I enjoy it. Fresh foods and I like the puddings." The cook showed us a list of people's special dietary needs, including diabetic and pureed meals, and likes and dislikes that was kept in the kitchen. She told us that she asked some people in a morning what they would like for lunch, but she asked them again at lunch time in case they had forgotten what they had chosen. They said that they always used sweeteners instead of sugar so that people with diabetes could have the same meals as everyone else.

There was a menu board with the choices for lunch recorded, although we noted there were no picture menus. Picture menus can help people with a cognitive impairment to choose a meal.

On the day of the inspection we observed the lunchtime experience in the main dining room and in one of the lounges. In the main dining room we saw that people were provided with special cutlery and crockery and that one person used a coloured plate to help them identify their food. People were offered a clothes protector. Appropriate assistance was offered to people and one person was encouraged to eat more. The cook offered people two choices of main meal and dessert, and people were asked if they had finished their meal before their plates were removed. People chatted to each other and to staff which made the mealtime a social experience. We heard people making complimentary comments about the meals and the cook. One person said after their meal, "I enjoyed that."

In the lounge people required more assistance to eat their meals and we saw that it was difficult for staff to assist everyone who needed assistance on a one to one basis in a timely manner. In addition to this, there was insufficient space for staff to sit next to the person they were assisting, so they had to kneel on the floor next to them. We discussed this with the registered manager and they told us they would consider serving meals at different times so that each person could have one to one attention and that staff could sit next to the person they were helping.

The home had achieved a rating of 4 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

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 MCA 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. We

Good

Is the service effective?

saw that care plans recorded the decisions people were able to make and the types of areas that might require a best interest decision. The relatives we spoke with understood about best interest decisions and they all said they or another family member had been involved in best interest meetings.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the service was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. We saw that documentation had been completed appropriately by the registered manager, and that the registered manager and staff displayed a good understanding of their role and responsibility regarding MCA and DoLS.

Staff told us that restraint was never used at the home. We saw that people had behaviour management plans in place to guide staff on how to manage situations if people became agitated or showed signs of distress.

People had a 'capacity and consent' care plan in place that recorded the types of decisions they were able to make. One care plan we saw recorded, "Decision making to be kept simple so [Name] can respond 'yes' or 'no' or 'I think so'. Staff to ask [Name] before any assistance given." Another care plan recorded, "[Name] struggles with sequencing. Staff to ask for consent at all times and explain actions." On the day of the inspection we observed that staff checked that people had consented to being assisted by them before they offered support.

Relatives and staff told us they thought the premises were suitable for the people who lived at the home. Staff told us that only two people had cognitive problems that meant they might find it difficult to find their way around the home. There was some signage in use but one person told us that clearer signs would help them. Some people required assistance from staff and they told us they did not require signage as staff made sure they found their way around. The registered manager acknowledged that they needed to introduce more signage to assist people in finding their way around the home.

Good

Is the service caring?

Our findings

Everyone who we spoke with said they felt staff cared about them. This was confirmed by the relatives who we spoke with. One relative told us, "You can hear them talking, they are friendly and coaxing." Staff told us they were confident that everyone who worked at the home genuinely cared about the people they supported.

We asked people if they were kept informed about events at the home and issues that concerned them. Some people felt they were and some people were uncertain about this. However, people told us that staff took the time to communicate and chat with them. Comments included, "We have a good chinwag in a morning", "They are very good – they talk to me" and "They chat with me as they get me up."

People told us that staff respected their privacy and dignity. They told us that staff knocked on their bedroom door before entering and we observed that this was the case. One person said, "I feel very comfortable with them." Staff told us that they knew how important it was to respect people's dignity and to maintain their confidentiality. They said that they did this by "Attending to all people's needs in private", "Closing doors and curtains" and "By having as few people in the room as possible." Relatives told us that their family member's privacy and dignity was respected by staff at all times.

We saw that the dining room had been extended and that this created a small seating area at the end of the room. This provided space for people to meet with relatives and friends if they wished to see them in private.

We saw that care plans recorded whether people wished to be assisted with personal care by a male or female carer and that both male and female care workers were employed at the home so this could be met. There was a board that displayed which staff were on duty each day. This meant that people knew who would be supporting them each day. We saw that the people who lived at the home were clean, appropriately dressed, had tidy hair and were wearing appropriate footwear. Men were clean shaven [if this was their wish].

Relatives told us that staff supported their family member to be as independent as possible, although two relatives said their family members were not able to do very much for themselves. Staff told us that they promoted independence. One member of staff said they supported people to remain independent "By letting them do as much as they can and then offering to help if people were struggling" and another told us, "By continuing to encourage them to do the tasks they can do." At lunchtime we observed that a member of staff said to someone, "Would you like me to help you?" rather than providing help without checking with them first.

Some people's care plans included information that had been obtained from the NHS Choices website about specific illnesses; this helped staff to understand the person's condition and provide appropriate care, support and information to people.

We saw the 'night time' checklist that was used by night care workers every night. These recorded that people were checked at two hourly intervals during the night to make sure they remained well and to check whether or not they required any assistance.

We noted that some people had Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] notices in place and these had been completed correctly. We saw there was a list in the medication room to record which people living at the home had a DNACPR in place as a quick reference for staff should an emergency occur.

Good

Is the service responsive?

Our findings

The care plans we saw included care needs assessments, risk assessments and care plans. A pre-admission assessment had been completed prior to the person moving into the home, and this information had been developed into an individual plan of care. People who lived at the home had care plans in place for promoting personal needs, diet, medication, mobility, social / leisure, pressure care, mental health, communication, infection control and capacity / consent.

Care workers told us that care plans were developed from information gathered from the person themselves, their family and friends and from health and social care professionals involved in their care. People had 'initial observations' recorded at the time of their admission so that staff could identify any needs the person had that were not already recorded in their care needs assessment or care plan.

Some people who lived at the home could not verbally communicate their needs to staff. In these instances, care plans recorded the signs that staff needed to look out for and what they might mean, for example, "If arms are folded across [Name's] body with hands up her sleeves, she may be cold." Another person's care plan recorded, "[Name] is unable to alert staff of any pain or discomfort but will show through her body language and facial expression."

People who we spoke with told us that their care was centred around them. Although people told us they were not aware of their care plans, relatives told us they had been involved in developing their family member's care plan. One relative told us they had "Lots of involvement – we have gone through it a few times." We saw that care plans included a section for people to sign to record they were aware of their care plan; relatives were asked to sign this if their family member was not able to do so.

It was clear that care workers knew people's individual personalities, wishes and care needs. Staff told us they got to know people by reading their care plans and talking with them, their family and friends and their GP. They said they would also speak to the registered manager, as she undertook an initial assessment before people moved into the home. We saw the daily handover book that was used by staff to record the latest information about people who lived at the home. There was a day and an evening handover sheet, and we saw that each person's name was listed and a brief entry had been made to pass on information for the next shift of staff. The form also recorded the names of the staff on duty, any messages in respect of people's medication and information received from or about involvement with outside agencies.

In the same folder there were sheets to record people's food and fluid intake [including food supplements], behaviour management charts, 'coughing' charts, blood sugar monitoring charts and a bedrail safety checklist when this monitoring needed to be in place, and a bath / shower checklist in respect of everyone who lived at the home. This meant that staff had easy access to the information they needed to help them keep up to date with people's specific care needs. It also meant the registered manager had access to this information so they could check that staff were following people's care plans.

We saw that care plans were reviewed in-house every month and that more formal reviews were undertaken by the local authority when they had commissioned a service from the home. Staff told us that people's views were listened to at review meetings. We noted that some updates in care plans had not been clearly dated, although there was no reason to suggest that care plans were not up to date.

People told us there were activities they could take part in; they mentioned exercise classes and a singer. One person said, "I go down to do exercises and when a man comes in to sing" and another person told us, "I have a go at anything." Other people told us they preferred not to take part in organised activities. Comments included, "I am not interested in doing any – I like my TV" and "I like my knitting and my word searches and TV." This showed us that people could choose whether or not to take part in organised activities.

We saw there was an activities board on display and the activities planned for each day were advertised. On the day of the inspection the activity advertised was 'music and a sing-along' and we saw that this activity took place. People were invited to go into one of the lounges and we saw that they enjoyed taking part; the staff member concerned encouraged conversation as well as taking part in an activity. The member of staff then did some gentle exercises with people. Staff also told us that they had regular visits from a hairdresser and that they helped

Good

Is the service responsive?

people with nail care if they wished to have their nails manicured and varnished. When any outside entertainers were due to visit the home, a poster was displayed so that people knew which day this would be taking place.

There was a book where all activities were recorded. This recorded the activity offered each day and which people had taken part. Activities offered included music and films, card games, bowls and sing-alongs. Records showed that 50% of people usually joined in these activities.

People told us that their family and friends were made welcome at the home and that people were supported to remain in touch with their relatives, friends and the local community. On the day of the inspection we saw that staff went out of their way to make visitors welcome and offered them refreshments and a comfortable place to sit. Staff told us, "We have a good relationship with family members – we contact family if requested" and "We welcome visitors and [people who live at the home] have mobile phones, postcards and letters." Another member of staff told us that one person attended church with a relative every week and that other people went out with family members.

We asked people if they felt they had choice and control over their lives and they said that they did. Comments included, "I do what I want to do" and "I choose to have my meals in my room." Staff told us, "We ask them and give them choice", "We ask them their choices – you get to know them." and "By encouraging them to be independent, and supporting them to make decisions."

We saw that the complaints procedure was displayed in the home and the manager told us that it was also included in the home's statement of purpose. We saw that there was a form ready for use to record complaints, comments and suggestions although the registered manager told us they had not received any formal complaints during the previous year.

People who lived at the home told us that they could raise issues and they were confident they would be dealt with. They all named people who they would be happy to speak with and they all said they had not had any complaints so far. One person said, "I'd tell a carer or [the manager] – never had a complaint whilst I have been here – I am treated well" and another told us, "I would tell [the manager] – I love her to bits." Staff told us they would listen to a person's complaint or concerns and would deal with the complaint immediately if they were able to do so. Otherwise, they would report the issue to the manager or deputy manager. Staff said they were confident that managers would listen and investigate the person's concern or complaint.

The relatives we spoke with told us they would speak to the manager if they needed to make a complaint, but that they had never needed to. One person said, "I would tell [the manager] but I can't think of any."

Staff told us that there were meetings for people who lived at the home. They told us there was a meeting before Christmas when they discussed activities over the Christmas period. Staff told us, "We listen to their views." We saw the minutes of this meeting and noted the topics discussed included Christmas, staff, complaints, care plans and consent. People were told about the content of their care plans and who was allowed to read them. People who lived at the home commented that staff were pleasant and good at their jobs. At the previous meeting in October 2015 the topics for discussion were activities, meals, staff and care. People commented that meal portion sizes were sufficient and that they were happy with the lunchtime and teatime menu, although four people said they were not keen on baked beans. People said they enjoyed the activities but would like more. We saw that an activities board recorded that activities were now available every day, which showed people had been listened to.

People could not recall being asked for their views on how the home was being managed and if their needs were being met, although one person said, "They do ask me if I am ok." We saw that satisfaction surveys were distributed periodically; twelve had been completed and returned during 2015. There was also a survey available for people who had stayed at the home for respite care but we did not see any that had been completed.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection and they had been registered with the Care Quality Commission for a number of years; this meant the registered provider was meeting the conditions of their registration. This also led to the home providing a consistent service.

We asked for a variety of records and documents during our inspection. We found that these were well kept, easily accessible and stored securely.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

We saw that there were clear lines of communication between the registered manager and staff. The registered manager knew about the specific needs of people living at Prospect House. We asked people who lived at the home if they felt able to discuss things with the registered manager and we received positive responses from all of them. One person said, "Yes, I could ask her for anything" and another told us, "Yes, I spoke with [Name] this morning." Staff spoke positively about the registered manager. Comments included, "Fine, no concerns, constant support", "Very thorough and works alongside staff", and "We all get on, she is professional, she is 'hands on'." A health care professional told us, "The manager is fabulous. I have no concerns at all about this care home."

The relatives we spoke with could not recall being invited to attend a relatives meeting. However, relatives were sent satisfaction surveys. One of the three relatives we spoke with told us they had received and completed a satisfaction questionnaire. We saw that a questionnaire had been distributed in December 2015 and that seven responses had been received. These had not yet been collated by the registered manager. Surveys had previously been sent out to relatives in September 2014; the registered manager told us that the outcome of surveys were usually displayed on the notice board and included in the home's newsletter.

Only one survey had been completed by a health care professional during 2015 and we saw that all of the responses were positive.

Relatives told us there was a positive culture at the home and they could approach the registered manager at any time. Staff described the culture as, "Open – we all talk to each other and support each other", "Home from home", "Relaxed and friendly" and "We discuss anything and everything."

The registered manager told us that the culture of the home was "A family run business. We aim for people to have fulfilling lives. We get to know people easily and quickly, we have a consistent staff group and we are very open." They said that they would never ask staff to carry out tasks that they wound not do themselves. A health care professional described the atmosphere of the home as, "Well organised and positive with good working relationships."

Staff told us they attended staff meetings every two or three months. They said they were happy to ask questions at these meetings and felt they were listened to. One staff member said, "When we are all together we open up and talk." We saw the minutes of a staff meeting held in August 2015. These evidenced that the topics of recruitment, refreshments [including the use of thickeners for drinks], legislation, Christmas and training booklets were discussed. We noted that the registered manager had passed on 'thank you' comments to staff as they had received positive feedback about the care people received. A meeting for kitchen staff had been held in October 2015; the minutes of this meeting showed that menu ideas, temperature checks, shopping lists and CQC requirements had been discussed. There was a notice displayed on the notice board informing staff that the next staff meeting would be held in January 2016.

The home did not have any written visions and values but there was a notice displayed in a communal corridor that listed the home's Charter of Rights, as well as information about advocacy services, the Alzheimer's society and Healthwatch; Healthwatch is the independent consumer champion for health and social care in England.

We asked staff if there had been any learning from incidents or complaints received by the home. They told us that there were previously two people who lived at the home who disagreed; after staff had consulted with them,

Good

Is the service well-led?

they decided that they should sit in separate lounge areas and there had been no further concerns. Staff said, “Any situation that has occurred is discussed at changeover” and “Any concerns would definitely be talked about.” One member of staff told us, “If ever we have done anything wrong, [the manager] takes us to a side in private and discusses it with us.”

Audits were carried out on various topics such as accidents / incidents, cleaning and ‘manager’s observations’. The manager also checked that the weekly and monthly maintenance checks had been carried out as required. These included checks on water temperatures, emergency call bells, fire safety, mattresses, communal rooms and medication. The communal room checks recorded when action had been taken, for example, when light bulbs had been changed or carpets cleaned. We saw the audits that had been completed for 2015 and noted that the audit forms had been prepared ready for use in 2016. We saw that audits included space for comments and concerns to be recorded, and when any required action had been taken.

We asked if there were any incentives for staff. We were told that the registered provider and manager were currently considering this; they had recently introduced a ‘top up’ fee so they could pay staff more than the minimum wage. They planned to give people a pay rise when they achieved a NVQ award. Currently, staff were not expected to pay for their meals, they received a Christmas bonus, an Easter gift and the organisation paid for everyone to have a meal out at Christmas.