Barchester Healthcare Homes Limited

The Reigate Beaumont

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

Summary of findings

Overall summary

The Reigate Beaumont is registered to provide accommodation and nursing care for up to sixty people. The home is located on the outskirts on Reigate town and close to local amenities. The home is owned and operated by Barchester Healthcare Homes Limited a major provider of social care in the UK. The home can offer respite care and long term care. People had access to several communal lounges and dining areas which overlooked attractive gardens.

The service had a registered manager in post on the day of the inspection visit. '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 and associated Regulations about how the service is run.

Risks were well managed and when risks were identified assessments were in place to minimise the risk to people. These were supported by guidance in people's care plans to help keep them safe.

There were sufficient numbers of staff who were appropriately trained to meet the needs of the people who lived at the service. Staff received regular support in the form of annual appraisals and formal supervision.

Staff recruitment procedures were robust to ensure that staff had appropriate checks undertaken before they commenced employment.

People were protected from the risk of abuse. Staff had received training in safeguarding adults and were able to evidence to us they knew the procedures to follow should they have any concerns. They told us they would report anything they were uneasy with to the nurse in charge.

Medicines were well managed and people had their medicines when they needed them. All medicines were administered and disposed of in a safe way.

Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the persons rights were protected.

People were encouraged and supported to be involved in their care. People's bedrooms had been decorated to a good standard and were personalised with their own possessions. One person was able to have their dog with them.

Health care needs were being met. People had access to a range of health care professionals, such as the GP, a community psychiatric nurse, dentist and opticians. Qualified nurses managed some health needs of people.

People told us the food was very good and there was lots of choice. We saw people had access to drinks

and snacks at any time during the day or night.

Staff were kind and compassionate. We saw people were treated with and respect and their privacy and dignity was respected at all times. For example staff knocked on people's doors before they entered their room.

People had individual care plans which gave clear guidance to staff on what support people needed. They were detailed and updated regularly. Relatives told us they had been consulted regarding people's care plans and were able to attend reviews of care.

The registered manager operated an open door policy and we saw several examples of people, relatives and staff visiting the office to discuss various subjects or just for a chat. The registered manager also ensured she visited people in their rooms if they were unable to access the open door policy.

People were aware of the complaint procedures and told us they would know how to make a complaint. A relative told us they were satisfied with the way their complaint was managed.

The registered manager had ensured that accurate records relating to the care and treatment of people and the overall management of the service were maintained. The registered manager and deputy manager had systems in place to record and monitor the quality of the service provided and to make improvements where necessary. Accidents and incidents were recorded and acted upon.

People would be protected in the event of an emergency at the home. Staff were aware of the home's contingency plan, if events occurred that stopped the service running. They explained actions that they would take in any event to keep people safe. The premises provided were safe to use for their intended purpose.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were cared for by a team of qualified and skilled nursing and care staff to meet their needs.

Risks were assessed and managed well, and risk assessments provided clear information and guidance to staff.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of the safeguarding adult's procedures.

People received their medicines as prescribed.

Staff were recruited safely, the appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

Is the service effective?

Good

The service was effective.

Staff received regular training to ensure they had up to date skills and knowledge to undertake their roles and responsibilities. They also received supervision.

Mental Capacity Assessments and best interest meetings were in place for people where they lacked capacity. DoLS authorisations had been applied for where people's freedom was restricted.

People had enough to eat and drink and said they enjoyed their food.

People's health care needs were being met and they were supported to remain healthy.

Is the service caring?

Good

The service was caring and sensitive to people's needs.

People were well cared for and their privacy and dignity was maintained.

We observed staff were caring and kind and treated people kindly and with respect.

Staff were friendly, patient and discreet when providing support to people.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs.

Care plans were well maintained and people's needs were fully assessed before moving into the service.

There were a wide range of activities available to people.

Complaints were monitored and acted on in a timely manner.

Is the service well-led?

Good

The service was well led.

The registered manager had system in place to monitor the quality of the service provided.

The registered manager had maintained accurate records relating to the overall management of the service.
Staff said they were supported by the manager.

People were asked for their views on the provision of service and these were used to drive improvement.

The Reigate Beaumont

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 16 February 2016 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection, we reviewed all the information we held about the provider. This included information sent to us by the provider in the form of notifications and safeguarding referrals made to the local authority. Notifications are information about important events which the provider is required to send us by law. The provider completed a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 12 people, ten members of staff, the registered manager, the deputy manager, seven relatives and two health care professionals.

We spent time observing care and support being provided. We read five people's care plans medicine administration records, recruitment files for staff, mental capacity assessments for people who used the service. We also read other records which related to the management of the service such as training records, policies and procedures and quality auditing systems.

The last inspection of this service was 19 September 2013 where we found the regulations were being met and no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe and did not have any concerns about the service. Relatives told us they were confident their family members were safe. One relative said "I'm delighted with this place, I have no regrets that we chose it. We are very reassured that he is somewhere where he is safe and well looked after." One person said "It is a safe place for me and I am contented."

People were safe from harm because the provider managed risks to people's safety. When hazards had been identified risk assessments were in place to manage them. These were detailed and contained information for staff to follow around what the risks were to people and the measures needed to be taken to reduce the risk of harm. Risk assessments included moving and handling, and provided staff with guidance on how to move people safely without compromising their independence. This included the number of staff needed to move a person safely and what type of slings to use if a hoist was required. Another risk assessment relating to nutrition ensured people were provided with a balanced diet and sufficient fluids to stay healthy. When people were at risk of developing a pressure ulcer the risk was managed and the appropriate pressure relieving equipment was provided to minimise the risk to that person. Input from other health care professionals was also used to support this. These were constantly updated either routinely or when needs changed. Staff had a good understanding of risk. One staff member said "We use bed rails for a person who may fall out of bed and regular checks are undertaken to ensure they are safe." Another member of staff told us they had to turn someone in bed every two hours as they were not well and at risk of "getting red skin." They deputy manager told us they constantly managed this to promote best practice and reduce the risk of pressure ulcers. Guidelines in people's care plan supported this.

People were safe because staff understood their roles with regard to safeguarding people from abuse. Staff had a good understanding of what abuse meant and the correct procedures to follow should abuse be identified. All staff members had undertaken adult safeguarding training within the last year in line with the provider's policy. Staff were able to explain the different types of abuse. One staff said "Abuse could be physical, mental, sexual or even denying people of their rights." Staff told us they had not seen anything that resembled abuse while working in the service and if they did they would report this immediately. Staff had access to contact details of the local authority should they require this. The provider was aware of their role and responsibility about informing the Care Quality Commission regarding any referrals made to the local authority under safeguarding.

People said there were sufficient staff provided to care for them. One person said "Staff are always there when I need help." Another person said "When I ring my call bell someone always comes quite quickly." We observed during our visit call bells were answered in a timely way. There were sufficient members of staff deployed to meet the needs of people. We looked at the staff duty rota for the previous four weeks. The rota revealed staffing levels were consistent across the time examined. There were eight care staff, two to three registered nurses, the deputy manager and the registered manager on duty during the day and three care staff plus two registered nurses on night duty. The registered manage used a formal tool, the Dependency Indicated Care Equation (DICE) to assess the changing care needs of individuals and calculate staffing accordingly. Copies of these assessments were kept in accessible place for information. The service also

employed a chef, kitchen assistant, hospitality staff, housekeepers, a laundry assistant, an administrator, an activity coordinators and a maintenance person.

Staff told us they felt there were sufficient staff employed to keep people safe and meet their needs. They told us they never felt rushed when giving care and were able to spend time with people.

The staff recruitment procedures in the service were safe. Staff employment files contained information to show the provider had taken the necessary steps to ensure they employed people who were suitable to work at the home. Staff files included a recent photograph and a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with children or adults at risk. There were also copies of other relevant documentation including references, employment histories, photographic identification, job descriptions, and staff contracts in staff files. Appropriate checks were undertaken before staff began work.

People told us they were given their medicine as prescribed by their doctor. One person said "The nurse always asked me if I would like anything for pain." Another person said "I have to take my time taking tablets and the nurses are so patient with me." People received their medicines safely and in a timely way. There was a medicines administration policy in place and all staff administered medicines according with this policy and in line with the Nursing and Midwifery Council's (NMC) Code of Professional Conduct. Formal competency checks were undertaken to ensure medicines were administered safely and nursing staff had undertaken regular medicine awareness training.

The general storage of medicine was well managed. There was a dedicated lockable room for the storage of medicines, and a trolley used for medicines was also locked so that only authorised people could access them. Medicines were labelled with directions for use and contained both expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Medicines requiring refrigeration were stored in a fridge, which was not used for any other purpose. The temperature of the fridge was monitored daily to ensure the temperature remained within normal limits for medicines that needed to be stored at a cool temperature.

We saw good audit trails of how medicines were checked into the service and how medicines were returned to the pharmacy. The provider also undertook quality monitoring of medicine to identify areas for improvement and to ensure safe and effective handling of medicines.

The Medicines Administrations Records (MAR) charts for people were fully completed by staff when medicines had been given. People had a photograph at the front of the MAR so staff could be sure they were giving the medicine to the right person. Allergies were included in MAR charts for information.

Where people had 'As required' (PRN) medicine there was guidance for staff on when to administer this. We heard staff ask people if they were in pain and if they required any medicine for this. Staff followed the guidelines by signing when PRN medicine had been given and the information was shared at handover to ensure the staff knew medicine had been given.

Accident and incident records were reviewed to ensure appropriate action had been taken and lessons learned to reduce the risk of them happening again. Where someone had a high level of falls recorded the registered manager was proactive in seeking support from the falls team to reduce the frequency and promote wellbeing.

The premises were safe for people who lived at the service. Radiators were covered to protect people from

burns; and ramp access was provided as appropriate. Fire equipment and emergency lighting were in place and fire escapes were clear of obstructions. Windows had the appropriate restrictors in place to reduce the risk to people. .

People's needs had been identified so they would be supported in the event of an emergency. People had PEEPs (personal emergency evacuation plans) in place and the provider used a "traffic light" system to identify those people most at risk should an emergency such as a fire or flood occur. This was based on people's mobility, sensory awareness and mental capacity. Each person's plan contained information about the method of evacuation to be used, and evacuation aids required and the number of staff required to achieve this safely.

The manager told us the home had an emergency plan in place should events stop the running of the service for example utility failure. Staff confirmed to us what they would do in an emergency.

Good

Is the service effective?

Our findings

People were supported by a staff team with the skills and knowledge to meet their assessed needs. One person said "The staff are good and know how to look after me." Another person said "I have all the care I need and staff understands me."
Relatives told us they were happy with the way their family members care and support was undertaken and that staff seemed trained to undertake their roles.

The registered manager told us that all new staff completed an induction period in line with the recently introduced Care Certificate in health and social care. The Care Certificate is an identified set of standards that health and social workers adhere to in their daily working lives. Staff told us that when they commenced employment they worked alongside a senior member of staff until they were assessed as competent to undertake duties unsupervised. New staff were supernumerary for their first week to enable them to become familiar with some organisational policies and procedures. We heard the maintenance person undertaking fire safety awareness training with a new member of staff which included a full tour of the premises and the location of all fire exits, alarms, and extinguishers. Induction training covered twelve weeks and staff worked with a hand book which was signed at each stage. This ensured that people received care support from staff that had been appropriately trained.

All staff undertook training in subjects relevant to the care needs of people they were supporting. The provider had made training and updates mandatory for all staff in the following areas, health and safety, moving and handling, infection control, first aid, food hygiene, fire safety and safeguarding people from abuse. Staff were also encouraged to gain further qualifications and staff had been enrolled to undertake diplomas in health and social care

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Qualified nurses were encouraged to undertake training to further develop their career and keep up to date with best practice as required by the Nursing and Midwifery Council's (NMC) Code of Professional Conduct. The registered manager facilitated this by enabling nurses to attend external clinical training courses at local hospitals or at The Barchester Training Academy. Both nursing and care staff were positive about the training provided and said the organisation believed in training their staff. A staff member told us the organisation had a training academy which invested in them. "I started as a care worker and advanced my career and have been a registered nurse for two years."

Supervision sessions and yearly staff appraisals for staff had been undertaken or planned in line with the provider's policy. The registered manager told us that all staff received regular supervision every three months. Staff received support and guidance from the registered manager or their line manager and were able to discuss their performance. Records showed areas covered included general performance, achievements, objectives, and identified training needs. We also saw that issued raised were followed up from one session to the next. Staff told us they found supervision sessions useful. One staff told us "I like supervision because it's my time and I can discuss things that matter to me." Another staff said "It was useful when I was returning to work following a long break. I had weekly sessions and they were great."

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 make a particular decision any made on their behalf must be in their best interest and as least restrictive as possible.

We examined the care plans of people who required close supervision and support, which constituted a deprivation of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty was being met. In each case the provider had acted appropriately, having requested a Deprivation of Liberty Safeguards (DoLS) assessment and authorisation following a mental capacity assessment.

We noted people or their representative's consent had been sought in a wide variety of areas. These included whether they wished to manage their medicines independently or to be involved in care planning reviews.

Staff had a good understanding of the Mental Capacity Act 2005. They were aware of people's rights to make decisions about their lives. They told us they always asked for peoples consent before providing care, explained the reasons for the care and gave them time to think about their decision before taking action. Staff had undertaken training regarding the Mental Capacity Act 2005 and they demonstrated its use. We saw some good care practice throughout our visit when staff promoted choice regarding personal care, menu choice and activity participation.

People were supported to keep healthy. Care records showed people's health care needs were monitored and action taken to ensure these were addressed by appropriate health care professionals. People were registered with a local GP who visited the home weekly or more frequently if required. One person said they were able to keep their family GP when they moved into the service. People had regular access to dental care, a chiropodist, and an optician. We noted the provider involved a wide range of external health and social care professionals in the care of people. These included speech and language therapists, local authority DoLS Teams and Older People Community Mental Health Teams. We noted that advice and guidance given by these professionals was followed and documented. Appointments with consultants or specialists were made by a referral from the GP if people's health needs changed.

People told us they were very satisfied with the way their health care was managed by the service. One person said "They miss nothing and they call a doctor if they think I need one." Relatives told us the service was very good at keeping them informed about any new treatments or changes in their family member's health needs. Staff were knowledgeable about people's health care needs and said they would know if a person was unwell. They said people may be "off their food" or extra sleepy and then they would report this to the nurse in charge. One staff member said "I am always listened to and that's important when I am talking about how I found someone when I was undertaking care." Nurses monitored people's clinical needs. For example they monitored blood sugar if people had diabetes and took periodic blood samples. They monitored catheter care and undertook various dressings and wound care.

People had enough to eat and drink. People told us they enjoyed their food and were consulted about the menus and the food provided. People told us there was always a choice of meals and that they could have an alternative to the published menu if they wanted. One person told us "The food is very good. There is

plenty of choice and it is good quality." Another person said "The food is always good and my lunch today was very nice. There is always a choice."

Relatives told us their family member's dietary needs were being met and any specialist diets were known by staff. They said their family members enjoyed the food provided and they were able to join their family members for meals if they wished. One relative said "The food is very good Dad enjoys his food very much."

People were able to eat their meals where they chose. Some people chose to eat their meals in the communal dining rooms whilst others preferred to eat their meals in their own rooms. In the smaller dining room people who needed support to eat received this from care staff. They supported people to eat in a way that ensured people were comfortable and eating at their own pace. Staff communicated effectively with people whilst they were supporting them, asking them about their likes, dislikes and preferences for example "Do you like mushrooms? Would you like me to take the sauce off them."

We observed lunch in the main dining room. The atmosphere was relaxed and convivial and the dining room provided a comfortable and amenable environment with views overlooking the grounds. People were able to choose their meals from the daily menu and give their orders to a member of the hospitality team, who also provided drinks of their choice. The chef came into the dining room during the meal to seek people's views about the food they had been served.

Individual nutritional plans were in place that outlined people's specific dietary needs. These were based on the malnutrition universal screening tool (MUST). This identified individual risks and when someone required a soft or pureed diet, diabetic, low or high calorie, vegetarian or cultural diet. When people were assessed at being at risk of choking specialist input from the speech and language therapist (SALT) was in place to minimise the risk.

People's weights were monitored monthly to confirm they were having enough to eat and drink. The deputy manager who is also the clinical lead nurse and the chef met at least once a month to discuss any concerns about people's nutritional needs. The staff would monitor and record their food and fluid intake more closely, weigh them weekly, seek advice from the GP and consider introducing fortified drinks. Records we examined confirmed this. We also read the chef wrote in people's nutritional care plans and guidance to follow when people were not eating a balanced diet. An example of this was when a person did not want to wake up for breakfast so the chef prepares a bowl of finger food like fruit and savoury snacked they can eat when they decided to get up.

Good

Is the service caring?

Our findings

People told us they had good relationships with staff and that staff were kind and caring. One person said "I love it here, it's marvellous. The care is superb. The staff are wonderful." Another person said "The staff are excellent, they are very kind and caring. We all get along very well together." A third person said "The staff are all very good."

Relatives spoke highly of the care provided by staff. They said that staff knew their family members' needs and provided care in a kind and sensitive way. One relative said us "We are very happy with the care" and another relative said "Their family member gets on very well with the staff. He has a joke with them and they have a joke with him."

Relatives said they could visit whenever they wished and they were made welcome by staff. One relative told us "The staff are very welcoming to us as visitors. We are always welcomed with a smile and the offer of a cup of tea."

Staff promoted people's dignity and privacy. A member of staff told us "I always make sure the door is closed and curtains are drawn before I undertake personal care, it is what I would expect myself." People's privacy and dignity was maintained and people received personal care in the privacy of their bedrooms or in bathrooms provided with lockable doors. If people wished to have gender specific staff to undertake personal care this could be accommodated in order to promote dignity. Staff knocked on people's doors and waited for a reply before entering. We noted people were addressed by their preferred name which was usually their first name. When people's care and treatment was discussed this was done in the privacy of the nurses office to prevent other people and visitors from overhearing. The deputy manager said "It is very important we respect confidentiality at all times."

People had been involved in in making decisions about their care and treatment whenever possible. They were also encouraged to give their views on the quality of care being provided and if this met their expectations as agreed in their plan. One person said "They are always asking me if everything is to my satisfaction." A relative told us they made the choice for their family member to live at the service. They said the clinical manager continued to involve them in any decisions regarding their relatives care consulted them regarding changes.

The atmosphere in the service was calm and relaxed and staff spoke to people in a respectful yet friendly manner. Staff were proactive in their interactions with people, making conversation and sharing jokes. We observed that staff supported people in a kind and sensitive way, ensuring their wellbeing and comfort when undertaking care. Staff made sure they asked permission before intervening or assisting people. Staff encouraged people to make choices and interacted with people individually. They got down to their level and gave eye contact when talking with people and spent time explaining what they were going to do, listening to them and responding to their queries. Staff were knowledgeable about the people they cared for. They knew what time they got up and went to bed where they liked to spend their time, what activities they enjoyed and their preferences in respect of food and drink.

It was evident by observing care that staff had a good understanding of people's needs and had enough skills and experience to meet these needs. We saw two members of staff caring for someone who was in bed. They told us that it was that person's choice to spend the day in bed that day. They were able to support this person's choice and made sure they had meals and drinks of their choice and that personal care was undertaken in line with their care plan. Staff were aware of people's routines and what mattered to them. One staff member told us that one person liked to visit the hairdresser who was in the service that day. "It is important I get this person up first as they like to have a shower and breakfast before having their hair done. That way there is no rush and the person is happy."

Bedrooms were pleasantly decorated and people had the opportunity to bring personal possessions, photographs, ornaments and items of furniture with them into the home. One person said "That was my favourite bureau and I like having it with me." People had television sets and one person showed us their radio times with all their programmes of interest marked out to watch. Some people had mobile phones or land line telephones so they were able to maintain contact with family and friends. One person said "Staff will do anything possible to make sure we are cared for well."

One person was able to have their dog with them in the service as this was important to them. The staff supported them to and ensured the dog was looked after as the person was no longer capable of this.

Relatives told us they could visit their family member at any time and always found them well cared for. They could visit their relative in the privacy of their room or there were private areas throughout the home that people were able to use. Relatives told us that staff were always available if they wished to discuss any aspect of their family member's care and treatment. One relative said "They are happy to talk about his care and they consult us about his care plan."

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. One relative said their family member had "very specific support needs" and that the service had made sure staff had appropriate skills to meet these needs. The relative said "We were really impressed with their attitude here. Other homes we approached said they would accept them without really finding out about their needs but here they weren't prepared to say yes until they had done a full assessment of their needs. The staff here were keen to have the training they needed before they moved in. The service sent six staff to the hospital [where the resident was before they moved in] to receive training on how to manage the person's needs from the speech and language therapist. The speech and language therapist then visited the service to provide training to other staff who would be caring for them."

People had been consulted and included in their care as much as possible. One person said "The manager came to assess me before I moved into the home. They asked me so many questions about myself and how I would like to be cared for, even what time I liked to get up." People had needs assessments undertaken before they were admitted to the service in order to ensure the service had the resources and expertise to meet their needs. Pre admission needs assessments were comprehensive and included all the information necessary to help make sure the home could meet people's needs. The service makes an informed decision regarding the placement. These were reviewed within weeks of a person being admitted to the service to ensure they reflected people's current needs within the service setting.

Care plans were well maintained and were reviewed monthly or more frequently when needs changed. This ensured staff had the most up to date guidance to deliver responsive care. Care plans were written with information gathered from the needs assessments, input from people and their relatives. Each care need was supported with an objective and guidance for staff to follow on how to achieve this. Staff recorded daily entries in the care plans about how care was delivered on each day. This information was communicated to the staff team during the shift handover to ensure continuity of care and that no important information was missed.

People told us there was a range of activities they could take part in if they wished. The service employed an activities coordinator who worked full-time. One relative told us "They were very good at providing activities and the activities woman is brilliant. There are always things they can do if they want to." People told us they could please themselves regarding activities. Some people liked to attend more activities than others. One person said "We have a bar evening this evening which is entertaining. It gets me out of my room for a few hours." An activity plan was displayed at reception and this took into account various celebrations and events for example valentine's day and pan cake day. Other activities included carpet bowls, quiz sessions, and "February events in history." Forthcoming events were also announced on the notice board to ensure people and relatives were kept informed. People who were confined to bed or who chose to stay in their rooms were offered one to one activities. This included hand massage, nail painting, reading aloud and listening to music. One person told us they liked their own company but would joined in activities when they were in the mood.

The service was responsive to people's mobility needs. Assisted bathing and toilet facilities had been provided to promote people's mobility. Grab rails were fitted throughout the service which provided people with the confidence to move about more freely. There were ramps in place enabling people to access the front and rear gardens with ease.

People had opportunities to give their views about all aspects of the service. We observed a residents meeting which took place in the main lounge. The residents meeting was attended by the registered manager, the chef, the activities co-ordinator and the maintenance officer. People were encouraged to give their views about these aspects of the service and to make suggestions for improvement. The registered manager told us that residents' meetings were held each month and that notes of the meetings were distributed to all people in the service to ensure that people unable to attend would be aware of issues discussed at the meeting.

People told us they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be addressed. One person said "Standards are generally excellent but if I wasn't happy with something I would certainly make a complaint." A relative said "I have not had to make a complaint but if I had issues I would go directly to the manager who I know would listen."

People had been provided with a copy of the provider's complaints process when they moved into the home. There was a copy of this displayed in the reception area where people, relatives and staff could access this. There was also a copy of this policy in people's care plans. This included clear guidelines on how and by when issues should be resolved. It also contained contact details of relevant external agencies such as the Local Government Ombudsman and the Care Quality Commission. There had been ten formal complaints made in the past year. The complaints had been resolved in a timely and satisfactory manner. The manager had written to the relevant parties with an action plan, where necessary to prevent further issues. We noted during the same period the provider had received four complimentary letters and numerous thank you cards in appreciation of the care and kindness provided.

Good

Is the service well-led?

Our findings

People told us how they felt about the service. One person said "The home is managed very well." People told us they were happy with the management arrangements in place. They said the registered manager and the deputy manager knew them well and were always willing to listen to what they had to say. They told us they felt the management team were capable and efficient.

Relatives told us they could talk to the management team at any time. They told us they were encouraged to take an active part in the life of the home and kept informed of family member's care and treatment. They also told us they were encouraged to participate in reviews of care and events that took place in the service.

Staff described the service as being caring and told us they were supported by the management team. One staff member said "They make sure we have the support we need to undertake our roles."

The provider had systems in place to monitor the quality of the service being provided and to make improvements when these were highlighted. The registered manager showed us a variety of audits undertaken by the provider and external audits. These included areas such as infection control, record keeping, medicine management, food safety nutrition and hydration and clinical improvement. The Lived Experience and Professional Practice audit was undertaken to review care plans and their relation to the day to day experiences of people living in the service. For example areas such as personal care, pain management, and maintenance of privacy and dignity were covered. The Clinical Improvement Plan composed of a quarterly report compiled following regular meetings attended by the registered nurses. Areas such as wound management, falls prevention, and medicines management were visited. The 'Quality First' programme consisted of a bi-monthly announced visit and audit conducted by the providers regional director.

All of these audits resulted in the production of reports which outlined an overview of service provision and action plans to improve quality and reduce risk. We looked at these and noted issues identified were dealt with by a named individual in the allotted time span. For example we noted the 'Quality First' audit had identified two areas for improvement. These were in provision of a pictorial guide to safeguarding adults to be made available and the addition of extra information to staff files concerning the recruitment of staff. From the 'Clinical Improvement Plan' we noted improvements proposed included the appointment of a clinical lead in medicine management.

Health and safety audits were undertaken to ensure the safety and welfare of people who used the service, people who visited the service and to promote a safe working environment. Records relating to health and safety for example maintenance checks, utility certificates, fire safety, and equipment were maintained to a high standard.

Staff meetings enabled staff to discuss any concerns regarding matters in the home or issues they had. Management listened and took action For example staff had felt there should be a designated laundry

person at weekends. This was addressed and there is someone now in post. The registered manager operated on open door policy and staff members were able to approach the manager at any time and were supported in an open and inclusive way. The registered manager's office was located on the top floor which was not as easily accessible to people with mobility needs. The registered manager recognised this and was going to consider locating their office to the ground floor with the approval of the directors. A member of staff said "It is important that we can talk with the manager and are listened to."

The provider monitored the quality of the service and generated a business plan to drive improvement. For example the service has a "Wellbeing project" in place which was taking place over the next ten weeks. This included refurbishing the reception area and developing a coffee and recreational area for people and visitors. Some rooms had also been identified for refurbishment to include new flooring." This was to enhance the facilities in the service and to keep the home clean and safe for people who lived there.

People, their relatives and their representatives were asked for their views about their care and treatment. These were sought via completed satisfaction questionnaires on a yearly basis. We looked at the latest results of the 2015 survey conducted by an independent agency, which received the views of 33 people living in the home. The questions people were asked fell into four categories which included staff and care, home and comforts, choice and having a say, and quality of life.
There were high satisfaction levels amongst people and their families, particularly in the area of quality of life and staffing and care. The home had been awarded an overall score of 850 out of 1000, up from 748 in the previous year.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed CQC of significant events that happened in the service in a timely way. This meant we could check that appropriate action had been taken.