New Care Homes Limited

Belle Vue Country House

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection.

Belle Vue Country House is a registered care home that provides nursing care and accommodation for up to 41 people. The home specialises in the care of people in the moderate or advanced stages of dementia and some people were unable to communicate verbally. Others had mental health conditions, for example, bi-polar disorder, manic depression or schizophrenia. At the time of our visit, there were 31 people living at the home. There was a registered manager present. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law, as does the provider.

People said they felt safe. One person referred to the staff and said, “They are all kind and caring and you have no reason to feel unsafe”. Staff were appropriately trained and had a good understanding of the Mental Capacity Act

Summary of findings

2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and safeguarding. Comprehensive risk assessments undertaken for people ensured that staff were able to meet their needs in a personalised way. There were sufficient numbers of staff on duty to ensure that people's needs were addressed in a timely fashion. People's human rights were properly recognised, respected and promoted. Medicines were managed safely in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately, including the administration of controlled drugs. The premises were suitably designed and equipped to ensure that people were able to move around independently or with support. The home was clean, free from infection and well ventilated.

The home effectively met people's health and care needs because staff communicated well with people, passed information about changes to their health or wellbeing across the team and sought advice and treatment from health care professionals as appropriate. Care records were detailed and reviewed on a regular basis. People were well nourished and their food and nutrition levels were monitored on a daily basis. Staff received essential training and additional training in areas such as end of life care, mental health and first aid. Staff meetings were held every two months and staff had one to one supervisions every month. People had their own furniture and rooms were personalised in line with their preferences.

People's personal preferences, likes and dislikes were recorded on file and staff treated everyone, including relatives, with kindness and compassion. A relative told us, "The staff looked after me. They kept me informed [about their family member] and helped me to get through a really difficult time". Staff knew people well and were keyworkers for named people, co-ordinating all aspects of their care and liaising with relatives and professionals. Where people were unable to make important decisions regarding their care, then advocates or named representatives were engaged. People's cultural and religious beliefs were catered for and they were treated with respect and dignity. End of life care was given in line with people's and relatives' wishes, in a compassionate and caring manner, by appropriately trained and caring staff.

Occasional social events were organised such as a summer fete and Christmas party. Access to local towns was limited, unless relatives took people out or taxis were arranged. Some people were able to access the local community independently. There was little in the way of physical stimulus for people with advanced dementia and some of the daily activities that were organised were beyond the understanding of some. Staff were encouraged to spend time with people and support them to be as independent as possible, to make decisions and choices. People received care that was responsive to their needs. The manager undertook comprehensive pre-admission assessments with people and their relatives that enabled staff to start to get to know people before they came to Belle Vue Country House. Care and support was planned appropriately in advance of admission. Complaints were acknowledged, investigated and responded to in a timely manner.

People were involved in all aspects of their care and in developing the service. Accidents and incidents were reported and recorded appropriately and plans put in place to prevent or minimise the risk of re-occurrence. Residents and relatives spoke highly of staff. One said, "Nothing but delighted. Made me feel so welcome. Always keen to have a chat, never seem rushed to do things". Staff had regular one to one supervisions and contributed to team meetings. There was an 'open door' policy at the home and the manager was readily accessible, as were nurses and other staff. A culture had been developed that encouraged the sharing of information and knowledge across the organisation. The registered manager played an active part in all aspects of the home. There were robust procedures in place to investigate complaints and concerns, as well as a whistleblowing policy.

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?

Requires Improvement

The service was safe.

People told us that they felt safe living at the home. Risk assessments were thorough and regularly reviewed. Staff knew what to do if safeguarding concerns were identified.

People's mental capacity was assessed and staff appropriately trained in this area. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. People's human rights were properly recognised, respected and promoted.

Medicines were stored appropriately and associated records showed that medicines were ordered, administered and disposed of in line with regulations. However, there were out of date eye drops in the refrigerator.

A downstairs toilet had a stained toilet pan and there was mould growing underneath a rubber mat in one of the bathrooms.

The home was clean and smelled fresh. Processes were in place to minimise the risk of infection.

Is the service effective?

Good

The service was effective.

People had access to a range of healthcare professionals such as a GP, physiotherapist, dementia care and mental health staff. Their current health needs were reviewed and monitored regularly.

People were well nourished and had a choice of food at mealtimes. Their food and liquid intake was recorded and managed.

Staff had received essential training and additional training to meet the specialist needs of people.

Is the service caring?

Outstanding

The service was exceptionally caring.

People were cared for by staff with great kindness and compassion. They were treated with respect and dignity. Relatives were also emotionally supported by staff.

Keyworkers were allocated to people and knew them well. They linked with professionals, families and friends to undertake reviews of people's care. They co-ordinated all aspects of care.

End of life care was provided to residents in a sensitive, holistic and caring way and in line with people's wishes. Relatives felt comforted by staff that went the extra mile to give them emotional support.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People were able to undertake activities organised at the service, although there were limited opportunities for some people to access the local community because there was no public transport. Social occasions were organised and enjoyed by people, relatives and friends.

People were assessed prior to admission so that staff could have a comprehensive picture of their health and care needs, likes and dislikes and cultural needs.

Complaints were acknowledged and dealt with within stipulated timelines. People could also raise any issues at residents' meetings, although they were not always interested in attending these.

Is the service well-led?

Good

The service was well-led.

People lived in a home that was well led by a registered manager who promoted a positive culture that was personalised to their needs, open and empowering.

People were involved in developing the service and were supported to do so.

Accidents and incidents were dealt with appropriately and measures put in place to mitigate the risk of reoccurrence.

Belle Vue Country House

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question, 'Is the service safe?' to 'Is the service effective?'.

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Belle Vue Country House was last inspected on 23 September 2013 and there were no concerns.

During this inspection we looked at various areas, including people's bedrooms, the kitchen, bathrooms, laundry, communal areas and grounds.

The inspection team comprised two inspectors and two experts by experience specialising in dementia and mental health. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern. We contacted a local medical practice who provided healthcare support to people who used the service. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, their relatives, healthcare professionals and staff. We spent time looking at records, including five care records, four medical administration record (MAR) sheets and records relating to the management of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Over the two days of our inspection, we spoke with 12 people living at the home, five relatives, the registered manager, a registered nurse, three care staff and six other staff in the kitchen, laundry and maintenance personnel. We also spoke with an Independent Mental Capacity Advocate (IMCA) and a GP, who were visiting the home at the time of our inspection.

Requires Improvement

Is the service safe?

Our findings

People had a range of needs relating to dementia or mental health issues. Some people were unable to communicate with us verbally, but others told us they felt safe. One person said, "They are all kind and caring and you have no reason to feel unsafe". A relative said, "I visit often and my husband has always said he is happy and staff are kind. I have not had any reason to feel that he is being abused". Another relative said, "I moved my wife from another home to come especially to Belle Vue. I am very protective of her and I keep a close eye on things here and I have no complaints. They keep me fully informed about things; I feel that she is safe".

We observed that residents were able to access their rooms, bathrooms and communal areas safely, with the assistance of staff or equipment to support them. Corridors had handrails attached at waist height to help people to move around freely. There was a ramp that enabled people with mobility difficulties to go out into a secure garden area. Hoists were used where needed to ensure that people were moved safely and these had been recently serviced. We observed two staff supporting one person to move safely from a wheelchair to an armchair with the aid of a Zimmer frame.

We looked at five people's care records and saw that mental capacity assessments had been completed appropriately and were regularly reviewed. For example, we saw in one care plan that the person had refused to participate in a 'mini mental state examination' and that this decision had been recorded and respected. All staff had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The training plan showed that the majority of staff had received refresher training on the Mental Capacity Act 2005 within the last year. A relative told us that their family member had a full assessment at admission and added, "Since he has been at Belle Vue he has calmed down and I feel that his keyworker has the experience to work with him. He is safe and cared for". The registered manager had a good working knowledge on DoLS and on mental capacity. They told us that three residents were subject to DoLS and that two of these would need re-applying for in September. We spoke with an IMCA who was visiting with a resident and they described the conditions of the DoLS relevant to one resident. The manager told us that they were in the process of applying for DoLS for the majority of residents, although four people were able to go out independently, either within the grounds or further afield. Residents were able to access the grounds freely if they could remember the keycode that operated the front door. If they were unable to remember the code, then they only had access to the back garden, rather than the extensive grounds surrounding the property that had open access to the road. One person told us, "I have the freedom to go out in the grounds for a walk".

Comprehensive risk assessments were in people's care records on areas such as moving and handling, behaviour, skin integrity including pressure sore risk assessments, pain and mobility. These assessments were regularly reviewed. There was information for staff on how to manage one person's verbal and physical aggression – 'Spend time talking about things that he likes as this tends to relax him. Give him time to calm down, then return to him again after some time and ask if he feels more ready'. One resident said, "I am well cared for by staff and I get my personal care needs done in a safe way, because I need assistance with getting out of bed."

Staff confirmed that they had received safeguarding training and were able to describe the various types of abuse. They also told us what they would do if they suspected abuse was taking place that they would write a report and refer to the manager or social services. One member of staff said, "If we see anything, we will report it and an investigation will be carried out". Staff received safeguarding training which was delivered by West Sussex local authority. We saw that staff had completed relevant reports and forms and notifications had been received by the Care Quality Commission.

There were sufficient numbers of staff on duty to keep people safe and meet their needs, including a registered nurse on each shift. Duty rotas confirmed this. One resident told us, "If I call for assistance they [staff] usually come promptly and that is why I think there are always enough staff on duty". We observed that there were sufficient staff available and that when people needed the toilet, they were looked after swiftly. Two staff files confirmed that the service recruited staff appropriately and checks to ensure people were safe to work had been undertaken with regard

Is the service safe?

to criminal records, obtaining references and proof of ID. The files also contained copies of staff's training certificates; staff confirmed they had received essential training, including safeguarding and DoLS.

We observed medicines being administered to people before lunch. We spoke with the staff member who was able to describe how they completed the medication administration records (MAR) and we witnessed this during the medicines round. Where people refused their medicine, the care staff would try administering this a little later. If the medicine was still refused then the record was completed to show this and the nurse or registered manager would be informed, so that appropriate action could be taken. We observed one person who was reluctant to take their medicine and that the staff member offered this through a straw, with sips of orange to make it more palatable.

Medicines were stored appropriately in two locked trolleys and controlled drugs were double locked within a medicines cupboard. Controlled drugs were listed and logged in a controlled drugs register. We checked that medicines were ordered appropriately and staff confirmed this was done on a 28 day cycle. Medicines that were out of date or no longer needed were disposed of appropriately. However, a bottle of eye drops stored in the refrigerator had been kept beyond the four weeks recommended. We were told that the eye drops were no longer needed and the bottle was disposed of appropriately. A resident's chocolate and fruit had been stored in the medicines refrigerator which was not good practice. We drew this to the manager's attention who told us that they would check the contents of the refrigerator more regularly to ensure that medicines were disposed of properly when no longer needed. They also assured us that the refrigerator would only be used to store medicines in the future.

Registered nurses and senior care assistants were trained in the administration of medicines. Training was refreshed annually and delivered in house by staff who were qualified to deliver training if staff were unable to attend external training.

Four or five residents were assessed as needing to receive their medicines covertly in food and this had been recorded appropriately in their care plans. The staff member we spoke with said that residents would be offered their medicines openly first then, if this was declined, the medicine would be administered in a drink or crushed in food. One resident said, "Staff give me my medicines. I always get my medication on time. The nurses are trained, so I have no reason to feel that they don't know what they're doing when it comes to medicines".

Records showed that fire drills were undertaken regularly and annual practice evacuations of the building were carried out. The fire alarm system and emergency lighting was checked regularly by the maintenance man. Fire extinguishers were in date. Checks had been undertaken on water quality (Legionella bacteria), lift servicing, boiler checks and electrical portable appliance testing (PAT). Appropriate checks and steps had been taken to keep people safe.

We spoke with a staff member who worked in the laundry who had received training in infection control. They described to us how the laundry was sorted. Residents' laundry was identified by name tags and sorted separately. Soiled laundry which posed a risk of infection was put into red bags and laundered at 75 degrees Celsius. Other staff confirmed that they wore white disposable aprons and gloves when attending to people's personal care needs and we observed this in practice. Clinical waste was disposed of in dedicated pedal bins which were emptied regularly throughout the day into a central locked disposal bin housed outside. The waste was then collected and disposed of by a specialist company.

The home smelled fresh and was ventilated, as it was a hot day. Cleaning rotas had been completed showing the daily and monthly deep clean routines. However, we saw that there was a badly stained toilet pan in a downstairs toilet and a build-up of mould encrusted limescale under the taps and seals around the sink area. In one of the bathrooms, a non-slip rubber mat on the shower seat had mould growing underneath, which posed a risk to health. We drew this to the manager's attention. On the second day of our inspection, the toilets and bathrooms had been thoroughly cleaned and the rubber bath mat had been removed. A relative said that their family member had a shower and their hair washed every day. Hand gels and alcoholic hand rubs were available at strategic points throughout the home, including the entrance hall. This minimised the risk of infection. There was a notice posted by the front door that warned people not to come in if they were at risk of passing on an infection.

Good

Is the service effective?

Our findings

People were having their lunch in the dining room and the food was served from a heated trolley. Whilst lasagne was on offer, people were able to choose an alternative if they wished. The menu had been written up on a board in the communal area. There was a choice of cold drinks available and people could help themselves to drinks from a trolley. Staff supported and encouraged people to eat their meals. One person was encouraged to eat a little more when the staff member said, "Have one more mouthful, then I'll stop nagging". The mood throughout lunch was relaxed and friendly and people were enjoying the food and each other's company.

Care records provided information to staff about people's food and nutrition. For example, 'To try and encourage her to have a good diet, provide protection so their bed doesn't become damp or messy. Try to offer choice where possible'. Records also showed how much people had eaten, for example, '1' indicated that nothing or very little had been eaten and '4' showed that the whole meal had been finished. People's food preferences were also recorded. We were told that there were no vegetarians or people who required specialist diets, although some people had soft foods if they had been assessed at risk of choking or had difficulties in swallowing. P

Belle Vue Country House is a large building set within extensive grounds. People had access to grounds at the front of the property and part of this had been landscaped as a sensory garden which they helped to plan. There was a secure garden at the rear of the property with seating and tables. One person said, "We can sit out in the garden if we wish and I think the gardens are beautiful". We saw people taking advantage of the hot weather, for example, they could have their meal outside or smoke a cigarette. There was a small aviary housing budgerigars and cockatiels. There was a main lounge and dining area and a smaller 'quiet' lounge. People were able to use the quiet lounge independently and take their drinks through to this area of the home.

People were able to have their own furniture and rooms reflected people's personal tastes. One relative said, "We were encouraged to bring items of furniture to make [X's] bedroom homely and I saw this as helping [X] to settle in the home and enhance [X's] dignity". Bedroom doors had name plates and depicted people's interests.

People were supported to maintain good health and have access and support from healthcare services. We spoke with a GP who was visiting the home. He said that he reviewed people's care every two to three weeks. He said, "Care's good. Staff are very kind and considerate to the patients, very respectful". We received an email from another GP who also visited the service stating that he had no concerns, that the manager and staff were knowledgeable, caring and conscientious. They added that some residents could be challenging because of their complex behavioural and psychiatric problems, but that staff were able to cope with these challenges.

People's current health needs were recorded on their care records. One person's care record gave instructions to staff which said, 'To assist the physiotherapy plan for her to spend more time out of bed during the day to reduce anxiety, distress of being hoisted. To use roll provided by physiotherapist to ease lengthening and strengthening of her legs'. Care records were reviewed monthly and updated to reflect any changes so that people's most up-to-date care needs were monitored and met. People had access to a range of external health professionals, for example, GP, physiotherapist, mental health or dementia practitioners. One relative was highly complementary about the support their family member had been given by an outside health professional.

Care staff had the necessary skills and knowledge to meet people's assessed needs, preferences and choices. Staff told us about the training they had received. Two of them were working towards qualifying as registered nurses. One said that they had undertaken extensive training as part of their nursing programme. They had also received training in health and safety, fire safety, end of life care pathway, care planning, infection control, food hygiene, dementia care, mental health and first aid. Specific training was organised if needed, for example, on HIV. Staff meetings were held, at least every two months. Staff confirmed that they received structured one-to-one supervisions with their manager every month. A staff member said they felt supported by their manager and other staff, "More than I thought I would be". Staff were trained and supported by management so that they delivered effective care.

Outstanding ☆

Is the service caring?

Our findings

People were treated with kindness and compassion. One person said, "Yes, they are really caring here and I am well looked after". Another said, "I've lived here I think for a number of years and they've always been good to me". A relative described how they found it difficult when they could not cope with looking after their family member at home any longer. They said, "The staff looked after me. They kept me informed and helped me to get through a really difficult time". In our observations, it was obvious that staff were as caring of relatives as they were of the people who lived in the home. Staff took the time to chat with relatives to see how they were feeling. People were looked after by staff who knew them well. We undertook a SOFI observation in the lounge area and observed that people were treated with warmth and gentleness. A member of staff said that they read people's care plans, but that it was "better to talk with them than read the files". They went on to say how one person they looked after was interested in cycling, painting and gardening.

A vicar from the local Anglican church visited the home every third Wednesday and people were invited to join in a form of worship if they wished; a Catholic priest also visited. The manager told us that a rabbi had visited in the past.

People's personal preferences had been identified and staff were allocated as keyworkers who co-ordinated all aspects of their care. Keyworkers provided the link between people and their relatives or friends and discussions took place when people's care needs were reviewed. Where people were unable to express their opinions independently, then advocacy services were available. Similarly, if people had no relatives or people to represent them, the home employed the services of a person who could be their 'named representative'. The manager said that 'best interest' meetings could be organised where professionals and relatives could get together to make a decision on someone's behalf. This showed that the home was making sure people were involved in the care they received wherever possible. A relative said, "I visit him every other day and I can see how staff care for the people here. I can say they do this very well, always speak to them calmly and request patient's views about how they can assist them". Another relative told us, "The nurse went through everything with me and explained what was happening. I was able to express my wishes and I was involved with the care planning. They ring me if anything happens or there are any changes which may need to be made in my wife's care".

People were treated with respect and dignity at all times. One person had required urgent personal care and asked for staff to assist them. We observed that a screen was placed around the person in order to maintain their dignity, whilst staff transferred them from an armchair to a wheelchair. We heard staff verbally reassuring the person throughout the process; this was done with kindness and sensitivity. We observed staff and people were getting on well with each other and in a very positive way. People were relaxed and comfortable with staff and there was a lot of laughter, which contributed to the informal atmosphere of the lounge area. When one person wanted to be alone, we saw staff withdraw and respect their wishes. One person told us, "I am always treated with respect, as you heard, the young lady [staff] knocked on my bedroom door before she came in". People told us that they could choose when they wanted to get up and when they wanted to go to bed. Mealtimes were also flexible.

Belle Vue Country House provided end of life care for residents. Staff were trained in end of life care and in advanced care planning. Advanced care planning is a way of determining what a person's wishes were with regard to their future care. Support was also provided from healthcare professionals and from staff at a local hospice who worked collaboratively with staff at the home. Staff were enabled to provide better care for people in the final years of life, to live well and to avoid, as far as possible, the need for hospitalisation. This holistic approach meant that people were able to make choices about where they wanted to be cared for as they approached death. We spoke with one person who had a life limiting condition. They told us that they had been able to return home for periods of time, but felt reassured that they could return to the service at any time to suit them when they needed more support. The care record showed there was an agreement between the manager and the person which included the dates for going home and when at the service. It stated, 'Should you experience any discomfort and need assistance from any of our nurses, ring the home. You can also come back to the home at any time if required. As part of this agreement, I may come and see you at home to see how you are getting on'. A relative told us, "I know my husband is not as well as he was and I realise that I don't

Outstanding ☆

Is the service caring?

want to think about the inevitable. I feel that the staff are preparing me gently for the end and I am grateful for that". Staff were exceptionally caring and treated people in a compassionate way that respected people's privacy and dignity. They were also empathic and sensitive to relatives' needs and wishes, up to and beyond the time of their family member's death.

The service organised multi-cultural remembrance services from time to time. These afforded relatives and friends the opportunity to join with staff to remember their loved ones who had died.

Good

Is the service responsive?

Our findings

Whilst people could access the garden and grounds at Belle Vue Country House, their access to local towns was limited unless visitors took them out or they arranged their own transport. The home is in a rural setting, with no public transport links. Some people were able to travel independently by using a taxi to access the local amenities. Outings had been arranged with a trip to Brighton and the service organised summer and Christmas parties. One relative said, "We recently had a garden party here. Lots of people came. It was a really good occasion for the community, relatives and residents". We were told that one member of staff had, "Sat between two residents and held their hands because they had no relatives". A resident told us, "Once a week a family member takes me out and I am able to go and see my friends in the town. Staff do not object to me doing this". Activities were organised for people, usually in the mornings. The home had a member of staff who planned activities such as gentle exercise sessions, music and singing with percussion instruments and shared reminiscing games. We witnessed a game of musical Bingo which was enjoyed by some people, although others appeared disengaged or did not understand what the game was about. However, staff were encouraging and supported people to participate in the activity as much as possible. Many people were not reliant on the activities available and chose not to be involved.

We saw the home had pictures on the walls and flowers in the communal areas. Daily newspapers were available, however, there was little physical stimulus for people who had advanced dementia, such as interactive tactile activities or textured services. These would have provided people with something to do during the day when organised activities were not happening. Most people were encouraged to spend their days in the lounge areas, where they were attended to by staff. We saw that there were also some very frail people who were cared for in their rooms and that staff checked on people in their rooms regularly. There were no restrictions when relatives or friends could visit the home. Relatives felt welcomed by staff when they came to visit and were always offered a drink.

Residents' meetings had occurred in the past, although the manager told us that people were not generally interested. Staff obtained residents' views on a more informal basis as they supported them with day-to-day care. A resident said, "I do have conversations with staff and they always listen to what I have to say and they have reassuring words". Notes from a meeting held in April showed that a discussion had taken place about the sensory garden 'Strictly Come Gardening' which people had helped to plan and design. This subsequently won an award and funding from Haywards Heath Town Council. Formal relatives' meetings had also been organised in the past to seek their views about the quality and standard of the service. The manager told us that they were planning to re-instate these meetings in the future.

People received care that was personalised and responsive to their needs. A care record for one person stated, 'She doesn't like to feel she is a task to be attended to, rather than a person. Spend time with her beforehand. Discuss non-care related things as this helps her to relax and enables her to feel as if she is being treated as a person. Encourage her to make choices for themselves and involve them in decision making, e.g. choosing their own clothes to wear every day, choice of drinks and food, etc'. One person told us, "I have met with the staff and doctor to review my care needs" and another said, "I have a care plan and have contributed to the plan".

People were fully assessed prior to admission and relatives confirmed this to us. Records showed that assessment included input from the manager of the previous care home and other professionals. The manager told us they would talk with potential residents and their families so that they had a comprehensive picture of the person, their health and care needs, personal preferences and cultural needs. For example, one record stated, 'Met with daughter and explained difficulty we are about to face and we will need her support'. Care records were easy to access, clear and gave descriptions of people's needs, past employment and lifestyle. For example, 'A very good cook, loves fine cuisine'. One person believed that their dog lived with them at the home and would put food on the floor for it. This information enabled staff to understand this person and to support them appropriately. Actions plans were put in place that informed staff how they should address people's anxieties, behaviours and moods in a person-centred way. Keyworkers were allocated to people to provide continuity and consistency of ongoing care.

Complaints were acknowledged by the service within seven days of receipt and were investigated within 28 days. The complaints policy confirmed this. In the reception area, we

Good

Is the service responsive?

saw the CQC leaflet displayed, 'What standards can you expect?'. There was information regarding the fees, service user guides and how to make comments, complaints or suggestions. Where concerns or complaints had been raised, the manager held a meeting in order to address and resolve the issues. Contact details for the Commission were also displayed so that people could make contact if they felt their complaint had not been addressed satisfactorily. People and relatives said they had not had any concerns about the care or had to make a complaint, however, they felt confident to do so should the occasion arise. One relative told us that they had raised a number of minor issues and that the nurse had dealt with them straightaway.

Good

Is the service well-led?

Our findings

People were actively involved in developing the service and with all aspects of their care. They were encouraged to contribute their thoughts and ideas to the environment. For example, they helped to plan the sensory garden by building a 'Strictly Come Gardening Mosaic 2014'. The model for this was on show in the reception area. Social occasions were organised and the service had held a summer party recently.

A relative said about staff, "Praise them to the hilt. They are attentive, caring and kind. They are interested in us as well as the resident. Here for us as much as him". Another relative said that their family member had come for respite, then stayed permanently and said, "Nothing but delighted. Made me feel so welcome. Always keen to have a chat, never seem rushed to do things". Relatives confirmed that staff were approachable and that 'lines of communication were open'.

We found there was a transparent open culture in that knowledge and information was shared and developed in a way that encouraged people to work together collaboratively across the organisation. The manager had been registered with the Care Quality Commission since October 2010 and had developed the service to ensure that high quality, responsive care was delivered by suitably qualified staff to people with a wide range of needs. The registered manager played an active part in the running of the home and treated residents in a warm, supportive and friendly manner, as did all the staff we observed.

A quality assurance questionnaire had been sent out to relatives and other professionals, the results analysed and audited to implement changes. Relatives were very complimentary about the social activities that had been organised, external entertainers that had been engaged and individual celebrations for people like birthday parties. Other professionals provided support and input to the home. For example, the services of a local hospice to advise and support staff in end of life care; the services of an IMCA to speak with a resident.

Staff we spoke with were aware of the whistleblowing policy and the action that they would take if they had any concerns. The manager told us that staff were encouraged to raise their concerns and complaints without fear of recrimination. Supervision notes reminded staff of the whistleblowing policy. In notes of a staff meeting where concerns had been raised about a staff member, the manager had referred to the whistleblowing policy and action that would be taken.

Staff understood what was expected of them and staff meetings were held at least six times a year. Notes from one of these meetings recorded, 'If you see bad practice, please stop people. If one bad practice is accepted by the whole care team, you are not only letting yourself down, but the whole level of care'. Investigations, where required, into whistleblowing, safeguarding, complaints/concerns and accidents/incidents were thorough, questioning and objective. Quality of care was also discussed at staff meetings and what action needed to be taken to improve, for example, in the recording of ABC charts. There was a care plan tracker that ensured care plans were updated by the second week of each month.

Staff were motivated, caring, well trained, supported and open. They had regular one to one supervisions with their managers and could contribute to staff meetings. Staff had been recognised for outstanding service through a 'staff recognition award'.

Accidents and incidents had been recorded and outcomes clearly defined, to prevent or minimise re-occurrence. For example, following an incident, bed rails had been installed for one person after being risk assessed. Regular audits were in place with regard to medicines and overall monitoring and auditing was in line with outcomes and regulations. We discussed safeguarding issues with the registered manager who showed a good knowledge of when and how to report. There were effective arrangements in place to continually review safeguarding concerns, accidents and incidents.

The service had an 'open door' policy and anyone could have access to the manager, charge nurse or other staff members. Staff worked alongside each other to provide support. There was a clear hierarchy and structure of management. The manager stated in the PIR that they planned to improve the service by having named lead staff to take responsibility for various areas such as medication, training, fire safety, wounds and dressings, Parkinson's Disease and dementia.