Wessex Care Limited

Milford Manor Care Home

Inspection report

Milford Manor Gardens,
Salisbury.
SP1 2RN
Tel: 01722 338652
Website: www.wessexcare.com

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This was an unannounced inspection which took place on 17 March 2015.

Milford Manor Care Home is registered to provide care (without nursing) for up to 30 people. There were 26 people resident on the day of the visit. The house is an old listed building which offers accommodation over three floors. People have their own bedrooms and there are spacious shared areas within the home and gardens.

There is a registered manager running the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People, their relatives and care and health professionals told us that they felt the home was safe. They told us they had never seen anything they were uncomfortable with and one relative said, ''I trust the staff completely''. Care staff were trained in and understood how to protect people in their care from harm or abuse.

The home had enough staff to keep people safe although people with behaviour that may cause themselves or

Summary of findings

others distress or harm were sometimes left unsupervised. We recommended that the service seek advice about this issue.The recruitment process ensured the staff employed were suitable and safe to work with people who lived in the home. Care staff had built strong relationships with people who lived in the home. Staff members had good knowledge of people and their needs. The staff team were supported by the management team to ensure they were able to offer good quality care to people.

People were given their medicines in the right amounts at the right times. However, it was not always clearly recorded when medicines prescribed to be taken when necessary should be administered or what time, time specific medication was given. Since the inspection the service has told us how they have dealt with these issues. The home took all health and safety issues seriously to ensure people were kept as safe as possible. The home looked at any accidents and incidents and learnt from them. They tried to ensure they did not happen again, if possible.

The service understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. They registered manager had made the appropriate DoLS referrals to the Local Authority. Additionally they had taken any necessary action to ensure they were working in a way which recognised and maintained people's rights.

People were supported to contact GPs and other health professionals when necessary. People's relatives told us their family members were provided with very good health care. Health professionals told us the service worked closely with them to ensure people's health was properly looked after. People were offered good quality and nutritious food which was described as, ''very good''. Staff used physical intervention to help people to control behaviour that caused harm or distress to themselves or others. The service told us that they had made immediate plans for staff to receive specialised training in this area.

The service recognised people's individual needs. They provided activities designed to encourage participation so that people enjoyed their life. However, they recognised that some people enjoyed their life more if they were able to wander around or do what they felt comfortable with . People were cared for as individuals and their choices and wishes were respected. People were treated with dignity and respect and were encouraged to maintain their independence for as long as possible.

People's relatives, staff and other professionals told us the home was managed well. They had ways of making sure they kept the quality of care they offered to a good standard. However, some individual records did not contain enough detail to instruct staff what actions to take in specific circumstances such as behaviour management.

We recommended that the service seek advice on the deployment of staff to care safely for people whose behaviour may cause harm or distress to themselves or others.

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 not always safe.

People who had behaviours that could cause themselves or others distress or harm were not always supervised in shared areas of the home.

Medicines were generally given in the correct quantities at the right times. However, the time that time specific medicine was given (if given late) was not always recorded. The home had recorded no medication errors in the previous year.

Staff knew how to protect people from abuse or harm. People and their relatives felt they were safe living in the service.

Any health and safety or individual risks were identified and action was taken to keep people as safe as possible. The service had written plans so that people knew what to do in the event of an emergency.

Is the service effective?

Good

The service was effective.

Staff understood consent, mental capacity and deprivation of liberty issues. People were helped to make as many decisions and choices as they could.

People were helped to see GPs and other health professionals to make sure they kept as healthy as possible.

Staff were mostly properly trained to ensure they could meet people's needs. However, the service was providing further training for staff in the use of physical interventions and other techniques to help people to control their behaviour safely.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and dignity at all times.

People's requests for assistance were answered as quickly as possible. Staff responded to people with patience and understanding.

People were helped to keep in touch with their families and other people who were important to them.

Staff had developed good relationships with people and their families.

Is the service responsive?

Good

The service was responsive.

Staff knew how to care for people in the way they chose and preferred.

Summary of findings

The service provided activities that some people could choose to do. They recognised that some people were happier doing things on their own, even if it did not seem to be a very meaningful activity to others.

Care staff responded to people's requests for help quickly. They often helped people before being requested to do so.

Is the service well-led?

Good

The service was well-led.

The registered manager made sure that staff maintained the attitudes and values expected.

The registered manager and staff regularly checked that the home was giving good care. Changes to make things better for people who live in the home had been made and development was continuing.

Records in some areas needed to contain more detail so that it was clear what staff need to do to help people.

Milford Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. To look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 17 March 2015. It was completed by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the Provider Information Return (PIR) which the provider sent to us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at all the information we have collected about the service. This included notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law.

We looked at six care plans, daily notes and other documentation relating to people who use the service such as medication records. In addition we looked at auditing tools and reports, health and safety documentation and a sample of staff records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with five people who live in the home, two visiting health care professionals and a family member. We spoke with four family members over the telephone. Additionally we spoke with seven staff members, a visiting 'specialist in dementia care', the operational service manager and the quality assurance and training manager. We received written information from two health care professionals after the visit. We looked at all the information held about six people who lived in the home and observed the care they were offered during our visit.

Requires Improvement

Is the service safe?

Our findings

Two people told us that they felt safe in the home. One person said, ‘‘yes of course I’m safe’’. A visiting professional told us that during their daily visits they had never seen any staff attitude issues or anything else to cause concern, they said, ‘‘I have no concerns or disquiet’’. A professional told us via e-mail that during their weekly visits they had never seen anything they were not comfortable with. They further noted people, '' are very well treated and kept as safe as possible’’. A relative said their family member was, ‘‘completely safe and very well looked after’’ another said they, ‘‘trusted staff completely’’.

Staff knew how to protect people in their care. Training records showed that staff had received safeguarding training, 16 of the 26 staff had received up-dated training in 2014. Staff received safeguarding training as part of their induction and additional training when they had completed their probationary period. Staff confirmed that they had received training relating to safeguarding. They were able to tell us the action they would take in response to witnessing abuse, although one staff member was unaware of the external agencies they could report to. One told us ‘’ I think the manager would react positively and follow the right steps.’’ Staff members were able to explain what they would do if they were concerned about a colleague’s poor practice. They said they were aware of the whistle- blowing policy and would report it to the manager or their deputy. One commented that they thought the management team, ‘‘would handle it well.’’ Another said that they had reported concerns they had about a colleague to the manager and the problem had been addressed. Staff and managers did not always identify behaviours that caused harm or distress as a safeguarding concern. Whilst any serious physical harm was generally recorded as an accident or incident other less serious incidents were noted in daily notes but not specifically recorded as a safeguarding issue. Examples included unexplained bruising and scratches, a person sitting on others and a person taking other people’s food. A senior manager told us that the service discussed these events with the safeguarding team. However, we could not find records of these discussions or safeguarding referrals to the local authority. The Care Quality Commission (CQC) had not been notified of incidents that we identified as a safeguarding concern.

People’s care plans included any necessary risk assessments and instructed staff where to find the risk management plan. The risk management plan described how staff were to support people as safely as possible. Behaviour risk management plans were not detailed or clearly identified. The identified areas of risk depended on the individual and included areas such as falls, mobility and pressure areas. Staff members were able to describe the action they would take if people fell and/or sustained injuries. The service used recognised assessment tools for looking at areas such as nutrition and skin health.

The safety of the people who lived in the service, staff and visitors was taken seriously by the provider. There was a health and safety policy and procedure manual and a comprehensive generic risk assessment file, which was due for review in January 2015.There, were systems in place with regard to the management of health and safety and maintenance. A maintenance review had been undertaken on 9 June 2014. This contained an action plan along with dates for completion. Up-to-date maintenance certificates such as gas safety and electrical installation were available. A comprehensive health and safety audit had been carried out by an external auditor on 6 October 2014, an action plan had been written and actions had been signed off as completed. A fire safety assessment and water legionella check had been carried out in May 2014 and an asbestos survey had been completed. The infection control manual contained some audits, but these were out of date, they were last completed in 2012. However, the provider sent us copies of infection control audits completed throughout 2014. Different areas of infection control, such as spillage and contamination, hand hygiene and disposal of waste were audited every month.

Most of the people who lived in the home had personal emergency evacuation plans detailing the support people required should they need to be evacuated from the building. They were kept in the entrance hall. However, four people did not have evacuation plans and one had not been reviewed since 2012, we told the senior staff member on duty of our findings. The omissions would not impact on people because staff would continue to follow the service’s generic evacuation procedures. The service had an emergency plan called the ‘Business Continuity Plan’ in place dated March 2014. The operational manager told us that in the event of the building being evacuated, people would be taken to other nearby services owned by the provider. Detailed accident records were kept. A full

Is the service safe?

description of the accident, the investigation, if any and the actions taken were recorded. Action plans were reviewed monthly, comments were made and any actions to minimise the risk of recurrence were taken.

There was an odour in the downstairs corridor throughout the day of the inspection and the laundry was disordered and messy with a dirty pipe. However, the issues in the laundry were resolved before we left the service. Visiting professionals and families told us that the home was usually odour free and they generally had no concerns about the cleanliness or hygiene of the home. One professional said, ''there is sometimes a slight odour in the mornings but is gone by lunchtime''.

People were supported by staff who had been recruited safely. There was a robust recruitment procedure which included the taking up of references, criminal record checks and checks on people's identity prior to appointment. Application forms were completed and interviews held. Records of interview questions and responses were kept. However, the registered manager was not always involved in the recruitment process which was generally conducted by the provider and other senior managers. The provider explained that this along with other 'management' responsibilities was accepted by his senior team to free the registered manager to concentrate on giving good quality care to people in the service.

People and their families told us there were enough staff around to keep people safe. Relatives told us that staff were always very busy and one said, ''they could do with a few more staff to deal with some behaviours''. The senior staff member on duty (shift leader) told us there were usually five carers on duty to support the 26 people living in the service. There were seven carers on duty at the start of our inspection. On the day of the visit three staff had been called in because one person was displaying distressed behaviour and needed extra support and one permanent staff member had called in sick at short notice. One of the staff who had been 'called in' told us they had previous experience of working in the home over three years ago, but had only come back to help out once since then. They informed us that the senior carer on duty had, ''given them a handover'' in order to inform them of people's needs. They also told us that they had been allocated to work with one of the home's regular carers.

The operational manager told us that there were a minimum of five care staff during the morning shift (8am to 2pm), four during the afternoon (2pm to 8pm) and two staff during the night. Rotas for March 2015 showed that staffing levels had not dropped below those specified as minimum. They were more generally above the required numbers. Staff confirmed there were usually five staff, including the shift leader on duty from 8.00am. They said that this ''sometimes drops to four during the afternoons'' although staff were sometimes brought in to work from 2pm to 10pm if required. They stated they felt having five staff was, ''Ideal'' as there were some people who needed the support of two care staff for personal care. They told us that the number of staff at night varied between two and three. Some staff told us that two staff at night was not enough but that the manager was trying to get three staff as the usual number.

On some occasions during the day staff appeared to be 'rushed' or ineffectively deployed and were not able to fully supervise or support people in a timely way. Examples included staff not being available in the lounge area for approximately five minutes when a person was agitated, to 'defuse' difficulties between people. People were left for ten minutes in the dining area with one person verbally abusing another person. They were distressed because they had waited half an hour for breakfast. A person had to call for help on two occasions during one evening because they were being physically intimidated by another person. This meant that because of the needs of some individuals' people could be at risk. One relative said, ''it would be good to have a couple more staff when the behaviour of residents is challenging, this is more frequent than before''. Meals were served late to some people because staff were dealing with people's behaviour. The house was a complex layout with numerous corridors and separate accommodation areas which made staffing and supervision of people more difficult. However, the layout of the building afforded people more room and freedom to move around.

The provider told us they used a nationally recognised staff assessment tool called the 'Rob Fawcett tool'. The dependency of people and allocation of hours and staffing numbers were discussed weekly at a human resources meeting. Staffing was flexible and the operational manager told us the registered manager was able to request additional staff to ensure the safety and comfort of people, as necessary.

Requires Improvement

Is the service safe?

The service used a monitored dosage system (MDS) to assist them to administer medicines safely. This meant that the pharmacy prepared each dose of medicine and sealed it into packs. The medication administration records (MAR) were accurate. Written guidelines for when people should be given medicines prescribed to be taken as necessary (PRN) medicine were provided. The guidelines for medicines to be given PRN for pain relief were adequate but those to be given to support people to manage their behaviour did not contain enough detail to ensure they were given in a consistent way. An example of instructions for the use of PRN medicine included, '' give verbal input, talk [name] through process, always explain what is happening if distressed hxxx (illegible) for half an hour and xxxx(illegible) if this does not work then will have to administer [specific medicine]." This did not describe what the verbal input should be or how the person displayed distress. Illegible writing meant that some parts were not clear. However,staff were able to describe in exactly what circumstances and when they should give the individual the PRN medicine. After the inspection the provider sent us information to tell us that current PRN protocols had been reviewed.

The senior staff member was completing a medicine round during our visit. The medicine trolley was 'parked' against a hot radiator but was moved when this was pointed out to them. Staff were unable to tell us how many pills (not included in the MDS) were in stock. Examples included a staff member telling us there were 12 pills left when there was only one and that there were 13 left when there were 28. Staff were unable to explain why the daily records, interpreted by the staff member, did not 'match' the actual numbers. This meant there could be issues with regard to the timely ordering of medicines. After the inspection the provider sent us written evidence that a stock control record was in place and was used regularly. Staff told us the medicine round could take up to two hours but they did not record the time that medicine was given. Therefore, they may not give time specific medicines such as Paracetemol or antibiotics at the correct intervals. Care staff were trained to give people their medicines, however staff told us that their competence to administer medicines had not been tested since their initial training. The service had not reported any medicines administration errors in the past year. After the inspection the provider sent us information to confirm that they were planning additional training and competence testing in medicine administration for the appropriate staff. They also told us that the times that time specific medicines were administered would be recorded.

We recommend that the provider seek advice from a reputable source with regard to the deployment of staff to enable them to deal safely with people who may cause harm or distress to themselves or others.

Good

Is the service effective?

Our findings

People told us or indicated that they liked living in the home. One person said, ‘‘it’s really OK here’’. Relatives told us that their family members were, ‘‘well looked after’’. One relative said they were very happy that the carers had the skills to look after their family member. A health care professional who visited daily told us the home offered, ‘‘really good care’’.

People were helped to obtain support from appropriate healthcare professionals when necessary. Each person’s healthcare needs were described in their care plans. Health care professionals kept their own notes in the home so these were not always included on the home’s individual daily records. Specialist healthcare support, such as a diabetic control and how to meet individuals’ nutritional needs, was sought as required. A health care professional who was involved with the care of people who lived in the home told us that the home had a, ‘‘close relationship with community nurses who visit daily at present’’. A visiting professional told us, ‘‘we have a good relationship and rapport and the home phone us in a timely way if they have any concerns about anyone’’. They added, ‘‘I would be happy for a relative of mine to live in the home’’.

People’s consent was obtained during day to day activities. Staff told us how they would gain consent. One staff member said, ‘‘’’you always ask them, it’s not like we make decisions on their behalf.’’ They said that if a complex decision was required then they would involve ‘’A family member, doctor or lawyer.’’ Another told us that they would involve someone with power of attorney (a person who can legally make specific decisions on another’s behalf) or an independent mental capacity assessor. They demonstrated their understanding of consent, mental capacity and DoLS. The registered manager had submitted DoLS applications to the local authority. One had been completed, granted and notified to the Care Quality Commission (CQC) but the others were awaiting completion. People’s care plans noted who had power of attorneys but did not contain a copy of the paperwork to show what powers they had. Training records showed that 16 of the 26 care staff had received Mental capacity Act 2005 training which included understanding Deprivation of Liberty Safeguards (DoLS).

Staff, the operational manager and training manager told us that the home did not use restraint. Staff added that they had not been trained in the use of restraint but said that some people, ‘‘hit other residents’’. When asked what they did when this happened they replied ‘‘ We document it and report it to the manager and to the family’’. They told us that in the case of one person, they had contacted other health professionals who had advised them of how to use a specific physical intervention technique. This technique was not used as staff had not been trained in its safe use. During the visit staff used an intervention technique to ensure the safety of a staff member and a person who lived in the home. Whilst they had not been trained in the ‘escort’ technique observed they used safe moving and handling methods they had been taught. They used the intervention safely and prevented any physical injury to anyone. During the ‘feedback’ session the provider told us that he and other senior managers had recognised the increase in people’s harmful or distressing behaviours. They recognised that meeting the needs of people with advanced dementia may mean the use of different techniques to support them. They said they were looking at various systems which taught safe physical and other intervention techniques. After the inspection the provider sent us documents to show that they were reviewing the use of physical intervention for people with behaviour that may cause themselves or others harm or distress and providing appropriate training. They provided information about one person which showed they had reviewed their care plan and ways of dealing with the individual’s behaviour. The new guidelines for dealing with and reporting the individual’s behaviours would ensure people’s safety.

The environment was homely, well-kept and comfortable. There were easy read, pictorial signs on doors and walls indicating areas such as the lounge, dining room and toilets. People had memory boxes or photographs on their doors and pictures and family photographs displayed on their walls. The communal areas had ornaments , flowers and other ‘homely touches’. Relatives described the environment as,‘‘ very comfortable’’. A visiting dementia specialist said that the environment was,

‘‘suitable to meet the needs of the people who lived there’’. Two people had ‘gates’ across the door of their rooms which were operated from the inside. Care plans described why they were used and included the risk assessments for their use. Some call bells were tied up and not in people’s

Good

Is the service effective?

reach the reason for this were noted on care plans and risk assessed. The provider told us that a refurbishment of the home was planned and would take account of the special needs of people.

People told us food, ''is good'' and a relative said the food is, ''very good''. Breakfast was served late on the day of the visit because the chef had called in sick, at short notice. People were told breakfast would be late. However, some people were distressed because they didn't retain the information given to them. The operational service manager told us and menus showed that people had a choice of breakfast foods. However, on the day of the visit only different types of cereals and juices were offered. People did not ask for any alternatives. During lunch service people were given the meal they requested but if they did not eat it they were offered alternatives. One person was offered three alternatives for lunch although they chose not to eat any of them. Staff were patient and attentive when assisting people to eat their meal. However, some people had to wait for up to half an hour so that they could have the one to one support they needed.

The menus were well balanced and included healthy fresh food. Menus reflected special occasions such as Mother's Day and St Patrick's Day. Nutritional assessments, weight, food and fluid charts were completed for individuals, if necessary. One person had lost a large amount of weight in the previous twelve months. However, they were reviewed by the GP and community nurses on a weekly basis. These checks were not always recorded or cross referenced in the person's daily notes or reflected on their care plan. The person who had been called in to cook the meals on the day of the visit was knowledgeable about individual's nutritional needs including special diets and foods.

Staff were trained in the areas relevant to the care of the individuals who lived in the home such as dementia care. Training was delivered by a variety of methods which included e– learning and face to face training. Some staff told us they had achieved a National Vocational Qualification (NVQ). Staff told us, and records confirmed, they received formal supervision regularly approximately every two months. Appraisals were completed every year.

Good

Is the service caring?

Our findings

Throughout the visit staff were friendly towards people and they demonstrated a caring attitude towards them during our conversations. A health professional commented, ''I am increasingly impressed by the genuine caring approach of the staff and how they strive to preserve dignity''. A visiting professional told us, ''staff always treat people with dignity and respect''. Another said, ''the staff are very caring''. They said, ''people need a lot of support and they certainly get it''. A relative told us, ''the carers are very caring, respectful and kind''. They said they had observed their relative being got up and dressed and was very impressed with the way staff acted whilst carrying out the person's personal care.

People were encouraged to be as independent as they were able. Care plans noted how much people could do for themselves and noted how staff should encourage or support them to retain their independence for as long as possible. During the inspection staff were interacting and talking with people at all times. People were encouraged to express themselves and make as many decisions as they could. Staff carefully described what they were doing and why and people were asked for their permission before care staff undertook any care or other activities. Staff repeated themselves as many times as necessary, so that the person had as much opportunity as possible to understand and make their decision.

People were helped to maintain relationships with people who were important to them. Relatives and friends were welcomed to the home and there were no restrictions on times or lengths of visits. Staff were very knowledgeable about the needs of people and had developed good relationships with them and their families. One relative told us that they as well as their family member were, ''very well supported by staff and it is very nice''. A visiting specialist told us they were in contact with six or seven families with relatives in the home. They said they were all very positive about the relationships the staff had developed with them and their relatives.

The service had developed communication care plans for individuals, however they were not always very detailed. However, staff were able to understand people's behaviour and non-verbal communication methods and were able to communicate with people who generally understood them.

Care plans for people who required end of life care were not always clear. One person had two plans and it was not easy to identify which one was current. There was no clear care plan in place in order to direct staff in relation to providing adequate nutritional intake for end of life care. However, the person had been regularly seen and reviewed weekly by their GP. Records of fluid intake and output and two hourly positional changes were kept in the individual's room. These were accurate and up-to-date.

Care plans noted people's emotional, cultural and spiritual needs. A regular religious service was held at the home for those who wished to participate. Some care plans included end of life care wishes and funeral plans. Training in end of life care was planned for staff in 2015. Do not resuscitate forms were completed appropriately. They noted the discussions the GPs had with individuals, families and any other relevant parties.

Good

Is the service responsive?

Our findings

Each person had individualised care plans which described people's needs, tastes, preferences and choices about how they wished to be supported. Staff described personalised care and demonstrated their understanding of what this meant. They told us that the care plans and their knowledge of people meant that each person was treated in the way they wanted and according to their needs.

People attended their review meetings and were involved in their care planning, if they chose and were able to be. Relatives sometimes attended meetings on behalf of their family members. Care plans were looked at by key workers every month and people's views on their care, if they were able to express them, were noted on the reviews.

Staff responded quickly to people if they asked for or showed that they needed assistance. During lunchtime staff were able to identify when people, who could not clearly verbally express their needs, wanted help by their body language and behaviour.

People's activities were developed from the care plan which noted people's emotional and social needs. An example included someone who liked wildlife and had spent time in other countries. They were provided with wildlife photographs, books and videos. People chose if they wished to participate in the daily activities provided which included flower arranging, group meetings and pets and other animals visiting the home. Many of the people who lived in the home chose not to participate in the activities provided. People often chose to wander or pace and do whatever made them feel calmer. The activities people had participated in during the day were not always clearly recorded in their daily notes.

People's basic and additional care needs were allocated on a daily basis to individual staff according to their room number. The service used a daily allocation check list at handover so all staff knew what needs people had and how they should be responded to during the shift. The staff member in charge, all carers and night staff were identified on the list.

Two health professionals told us that the staff were always responsive to them, followed their advice and worked with them to ensure a good quality of life for the people they cared for. A dementia specialist told us the home responded very well to people's dementia needs. They said the home was, ''very non-regimented and gave people the freedom to walk about and wander''.

Relatives of people told us they knew how to make a complaint and wouldn't hesitate to do so, if necessary. They said they would go to the manager, if they needed to, but were confident that any staff member would listen to them and take action. One relative said, ''I have not had to make a complaint but I would be happy to or raise a concern with the manager of staff. I would probably go to Julie the manager who is amazing''. Another said they were happy to, ''raise a concern or make a complaint'' they felt they would be listened too by staff whatever their role and that they would do their best to correct things if they could. The home had a complaints procedure available to people and their families. The quality assurance and training manager took responsibility for all complaints received by the provider and ensured they were dealt with appropriately. The service had not received any complaints during the previous 12 months. The service responded immediately to issues that were brought to their attention at the feedback session after the inspection.

Good

Is the service well-led?

Our findings

People's relatives and health professionals told us the registered manager was, ''fair, had a good attitude and gave more than 100%''. They said she was very experienced but willing to, ''listen to and take on new ideas''. A relative told us, ''the manager always seems to be there when I visit, even if it's at weekends and she is very good at socialising with residents and relatives''.

Staff told us, ''the manager is always supportive. I have learnt lots of things from her. She is always open and listens to me''. Another said ''I love it here, everyone is supportive and friendly.'' They said about the manager ''She always listens. She is lovely, really easy to talk to; she makes it feel like a family.''

Staff meetings were held approximately three monthly. Staff said that they felt they were able to raise issues at meetings or during supervision and gave an example of when they had done so. One member of staff said, ''I like staff meetings. We discuss about our work, give suggestions. I feel like we work together ''. The provider held regular senior management meetings to discuss new innovations in good practice, the quality of care within the homes and other issues affecting the provider's services. An annual company management systems audit is completed by an external specialist organisation to check the provider was completing appropriate management systems for oversight and review of the services. This was last completed in December 2014.

The service held residents and relatives meetings for times a year, the last was held in January 2015. People discussed all aspects of the running of the home, developments and ideas for improvements. A relative said, ''I always go to the resident and relatives meetings which the owner and manager attend and things do seem to get done''. Changes made as a result of listening to people, the quality assurance and monitoring and reviewing systems included the timing of meetings and providing an identification of staff board by the front door. A new staff member was also recruited to oversee quality assurance and complaints for the company.

Resident and relative audits were completed every three months. The results from the questionnaires were collated by the clinical director who completed an action plan. Actions points and the person responsible for the action were noted and signed and dated when completed.

The home had a variety of internal reviewing and monitoring systems to ensure the quality of care they offered people was maintained and improved. The registered manager regularly worked in the home alongside care staff. She monitored staff attitudes and values whilst working with them to ensure they were offering care to the expected standard and according to the principles of the statement of purpose. Supervision records contained notes such as, ''witnessed good positive interactions [with residents]''.

The registered manager, staff, people and their relatives knew what roles staff held and understood what responsibilities these entailed. The operational service manager told us that the registered manager was given the authority to make decisions to ensure the safety and comfort of the people who live in the home. They said that the registered manager would usually make decisions about additional staffing with them or the provider but could make a decision in an emergency.

Records relating to people who lived in the service provided necessary information but some were not detailed. This made it difficult to 'track' changes in care plans such as up-dated end of life plans. Additionally areas such as identifying when to give medicines prescribed to be taken as necessary and behaviour management plans did not always clearly describe the actions staff must take. However, staff were able to describe what they should do even though it was not always clearly recorded. Records relating to other aspects of the running of the service were completed appropriately.

The registered manager and staff who worked in the service did not have access to a computer, on site. They were able to use computers located in head office which was a few minutes away from the home. However, this meant that the registered manager and other staff did not have instant access to some records, for example policy and procedure up-dates. This could cause a delay in them becoming aware of them.