Bupa Care Homes (CFChomes) Limited

Church Farm Care Home

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

This unannounced comprehensive inspection took place on 8 February 2018. The last inspection took place on 30 July 2015 when the service was meeting the legal requirements. The service was rated as Good that time. Following this inspection the service remains Good.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Church Farm is a care home which offers care and support for up to 60 predominantly older people. At the time of the inspection there were 44 people living at the service. Some of these people were living with dementia. The service occupies a building over two floors with passenger lift for people to access the upper floors. There was an on-going safeguarding investigation being carried out at the time of the inspection by the local authority. This incident is subject to a separate process and as a result this inspection did not examine the circumstances of that specific concern. However, the information shared with CQC about the incident indicated potential concerns about the management of risk in relation to the availability of equipment. This inspection examined those risks. We found that when people's health indicated they needed additional equipment action was taken to acquire it.

The records in care plans, relating to the powers of attorney held by some people living at the service, were misleading and inaccurate. Some care plans stated relatives held power of attorney for care decisions when they did not. This meant people who did not hold the appropriate legal powers could be involved in care plan decisions and reviews and were asked to sign consent forms which they were not legally able to do. We have made a recommendation about this in the Effective section of this report.

There were systems in place for the management and administration of medicines. Regular medicines audits were being carried out on specific areas of medicines administration and these were effectively identifying if any issues occurred such as the dating of prescribed creams when opened. We identified an issue with the length of time taken to complete the morning medicine round leaving only a short period of time before the afternoon round began. This could have implications for people on time specific medicines and pain relief. We also observed frequent interruptions of the staff member carrying out the medicine round. We have made a recommendation about this in the Safe section of this report.

The premises were well maintained. The service was not registered for dementia care. However, there were some people, who were living at the service with some early dementia. There was no pictorial signage for people who may require additional support with recognising their surroundings. The deputy manager told us this was constantly under review depending on people's needs.

The premises were regularly checked and maintained by the provider. Equipment and services used at Church Farm were regularly checked by competent people to ensure they were safe to use.

We walked around the service which was comfortable and appeared clean with no odours. People's

bedrooms were personalised to reflect their individual tastes. People were treated with kindness, compassion and respect.

Risks in relation to people's daily lives were identified, assessed and planned to minimise the risk of harm whilst helping people to be as independent as possible.

Staff were supported by a system of induction training, supervision and appraisals. Regular staff meetings took place to support each team of staff. Daily heads of service meetings took place to help ensure communication was good across the service. The registered manager was supported by the deputy manager and the provider with regular visits from regional manager, and a team of motivated staff at the service.

Risks in relation to people's daily life were assessed and planned for to minimise the risk of harm. People were supported by staff who knew how to recognise abuse and how to respond to concerns. The service held appropriate policies to support staff with current guidance. Mandatory training was provided to all staff with regular updates provided. The manager had a record which provided them with an overview of staff training needs. The provider monitored the service training provision against set objectives.

The service had identified the minimum numbers of staff required to meet people's needs and these were being met. The service had some staff vacancies at the time of this inspection. These vacancies were being covered by existing staff and no agency staff were used.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005. The principles of the Deprivation of Liberty Safeguards were understood and applied correctly.

Meals were appetising and people were offered a choice in line with their dietary requirements and preferences. Where necessary staff monitored what people ate to help ensure they stayed healthy.

Care plans were well organised. Care planning was reviewed regularly and people's changing needs were recorded. Daily notes were completed by staff.

People had access to activities. An activity co-ordinator was in post who provided a varied programme of activities for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Church Farm 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.

The inspection took place on 8 February 2018. The inspection was carried out by two adult social care inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is someone who has experience of using, or caring for a person who uses, such a service.

Before the inspection we reviewed the information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with ten people living at the service. We looked around the premises and observed care practices. We spoke with six staff, the registered manager, the registered manager and two representatives of the provider. We spoke with four visitors and an external healthcare professional. Following this inspection visit we spoke with two further relatives and a further healthcare professional.

We used the Short Observational Framework Inspection (SOFI) over the lunch time period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at care documentation for four people living at Church Farm, medicines records, four staff files, training records and other records relating to the management of the service.

Good

Is the service safe?

Our findings

We observed the medicine round taking place during this inspection. The morning round took from 9 am until 11.15 am with the next round due to commence at 1 pm. We were assured that no one had medicines which were time specific and that medicines which required a specific period of time to elapse between doses were monitored. The staff member carrying out the medicine round was carrying the telephone for the service and was interrupted on occasions by telephone calls. They did not wear a tabard, or indicate in any other way that they should not be disturbed during a medicine round, to help reduce the risk of errors being made.

We recommend the service review the process of the medicine rounds in order to reduce the interruptions to the staff member carrying out this task.

Some people had been prescribed creams and these had not always been dated upon opening. Some creams had labels upon them, which had held information, which was unreadable at the time of this inspection. This meant staff were not aware of the when the item may need to be disposed of. There was no lead person monitoring these items throughout the service. The deputy manager told us they were aware of this issue and were taking action to address it.

The service held an appropriate medicines management policy. There were medicine administration records (MAR) for each person. Staff completed these records at each dose given. From these records it could be seen that people received their medicines as prescribed. We saw staff had transcribed medicines for people, on to the MAR following advice from medical staff. These handwritten entries were signed and had been witnessed by a second member of staff. This meant that the risk of potential errors was reduced and helped ensure people always received their medicines safely.

The service was holding medicines that required stricter controls. The records held tallied with the stock held at the service. People's medicines and their records travelled with them when they went to hospital. Medicines that required cold storage were held at the service. There was a medicine refrigerator at the service. There were records that showed medicine refrigerator temperatures were monitored regularly to ensure the safe storage of these medicines could be assured. The service had ordering,storage and disposal arrangements for medicines. Regular internal and external audits helped ensure the medicines management was safe and effective. Some people required medicines to be given as necessary or occasionally. There were clear records to show when such medicine might be indicated and if it had been effective.

People were given the opportunity to self administer their own medicines if they wished. Staff monitored their medicines in their rooms to ensure people took their medicines appropriately. People had lockable storage in their rooms for the safe storage of their medicines.

Staff training records showed all staff who supported people with medicines had received appropriate training. Staff were aware of the need to report any incidents, errors or concerns and felt that their concerns

would be listened to and action would be taken.

Equipment used in the service such as moving and handling aids, wheelchairs, passenger lifts etc., were regularly checked and serviced by external contractors to ensure they were always safe to use. All necessary safety checks and tests had been completed by appropriately skilled contractors.

People and their families told us they felt it was safe at Church Farm. Comments included, "Oh yes, I know everything is fine," "I feel very safe when people come and talk to me," "[Person's name] is safe. I can tell they are well looked after, they are cheerful and calm" and "There's always people around at night. They put their head round the door and check up on you."

The service held an appropriate safeguarding adults policy. Staff were aware of the safeguarding policies and procedures. Staff were confident of the action to take within the service, if they had any concerns or suspected abuse was taking place. Staff had received recent training updates on Safeguarding Adults.

People living at the service were asked for their views about if they felt safe at the service. If anyone was involved in safeguarding enquires or investigations they were offered an advocate if appropriate or required.

The service had a whistleblowing policy so if staff had concerns they could report these and be confident of their concerns being listened to. Where concerns had been expressed about the service, if complaints had been made, or if there had been safeguarding investigations the manager had robustly investigated these issues. This meant people were safeguarded from the risk of abuse.

The service held a policy on equality and diversity, and staff were provided with training on equality and diversity. This helped ensure that staff were aware of how to protect people from any type of discrimination. Staff were able to tell us how they helped people living at the service to ensure they were not disadvantaged in any way due to their beliefs, abilities, wishes or choices. For example, if people were poorly sighted staff would read things out to them or support them to recognise where they were in the service.

The management team understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these as necessary. Staff told us if they had concerns management would listen and take suitable action. The manager said if they had concerns about people's welfare they liaised with external professionals as necessary, and had submitted safeguarding referrals when it was felt to be appropriate. Staff were clear about people's rights and ensured any necessary restrictions were the least restrictive.

Accidents and incidents that took place in the service were recorded by staff in people's records. Such events were audited by the deputy manager and overseen by the provider. This meant that any patterns or trends would be recognised, addressed and the risk of re-occurrence would be reduced. Records showed actions taken to help reduce risk in the future. For example, removing any hazards in the immediate environment of the person.

Risk assessments were in place for each person for a range of circumstances including moving and handling, nutritional needs and the risk of falls. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately in order to minimise risk and keep people safe whilst maintaining as much independence as possible. For example, what equipment was required and how many staff were needed to support a person safely.

Some people were at risk of becoming distressed or confused which could lead to behaviour which might

challenge staff and cause anxiety to other residents. Care records contained information for staff on how to avoid this occurring and what to do when incidents occurred. For example, one care plan gave clear guidance for staff about what would engage the person and distract them effectively.

Care records were stored securely but accessible to staff and visiting professionals when required. They were accurate, complete, legible and contained details of people's current needs and wishes.

The service held the personal money for some people living at the service. This money was held in personally named bank accounts, with a small petty cash float held at the service for access by people to purchase items such as newspapers and toiletries. The accounts for this money were regularly audited internally and externally.

The staff shared information with other agencies when necessary. For example, when a person was admitted to hospital a copy of their care plan and medicine records was sent with them.

We looked around the building and found the environment was clean and there were no unpleasant odours. The service had arrangements in place to ensure the service was kept clean. The service had an infection control policy and lead staff who monitored infection control audits. The staff had undergone a 'Glo box' experience. This is where the training room in which staff have been spending time has been sprinkled with an invisible powder which sticks to surfaces and items. Staff are asked to wash their hands thoroughly then put them in to an ultra violet light box which shows how much of the powder still remains on their hands. It is a useful method of teaching the importance of effective hand washing. The management team understood who they needed to contact if they need advice or assistance with infection control issues. Staff received suitable training about infection control, and records showed all staff had received this. Staff understood the need to wear protective clothing (PPE) such as aprons and gloves, where this was necessary. We saw staff were able to access aprons, hand gel and gloves and these were used appropriately throughout the inspection visit.

Relevant staff had completed food hygiene training. Suitable procedures were in place to ensure food preparation and storage met national guidance.

Each person had information held at the service which identified the action to be taken for each person in the event of an emergency evacuation of the premises. Fire fighting equipment had been regularly serviced. Fire safety drills had been regularly completed by staff who were familiar with the emergency procedure at the service.

Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of references.

The registered manager reviewed people's needs regularly. This helped ensure there were sufficient staff planned to be on duty to meet people's needs. The service had vacancies at the time of this inspection and these were being recruited to. The vacant posts were covered by existing staff and no agency staff were used. The staff team had an appropriate mix of skills and experience to meet people's needs. During the inspection we saw people's needs were usually met quickly. The staff held pagers which alerted them if a person required their attention.

We saw from the staff rota there were eight care staff in the morning and six in the afternoon supported by senior carers on each shift. There were three staff who worked at night. Staff worked well together and felt

the management team were very supportive.

The management team were open and transparent and always available for staff, people, relatives and healthcare professionals to approach them at any time. They understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these as necessary. Staff told us if they had concerns the management team would listen and take appropriate action. If there were concerns about people's welfare the management team liaised with external professionals as necessary, and would submit safeguarding referrals if it was felt to be appropriate.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The service held an appropriate MCA policy and staff had been provided with training in this legislation. People's capacity had been assessed were appropriate.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had not made any applications for DoLS authorisations at the time of this inspection.

People were asked to consent, where they were able, to their care and to have photographs of them displayed in their records. Where people were unable to consent themselves due to their healthcare needs, the service sought consent from family members. A person can only sign on behalf of another person if they have an appropriate Power of Attorney in place. The records for some people held inaccurate information regarding the powers held by some relatives. For example, one care plan stated a relative held a Power of Attorney for both financial matters and care decisions. When we checked the relevant documentation it appeared the relative only had Power of Attorney for financial matters. This meant people who did not hold the appropriate legal powers could be involved in care plan decisions and reviews and asked to sign consent forms which they were not legally able to do.

We recommend the service seek guidance from the Mental Capacity Act 2005 Code of Practice.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People chose when they got up and went to bed, what and then they ate and how they spent their time. People were able to go out in the grounds and local area as they chose. Some people required support to do this and this was provided by staff. There were also secure outside spaces that people could enjoy.

People's needs and choices were assessed prior to the service commencing. People were able to visit or stay for a short period before moving in to the service. This helped ensure people's needs and expectations could be met by the service. People were asked how they would like their care to be provided. This information was the basis for their care plan which was created during the first few days of them living at the service.

The use of technology to support the effective delivery of care and support and promote independence, was limited. However, staff carried pagers to alert them when people needed support.

Training records showed staff were provided with appropriate mandatory training. Staff told us they received regular training updates. Staff were also provided with training in additional areas such a pressure area care and managing behaviour that challenged. The management team monitored staff training against the providers targets.

Newly employed staff were required to complete an induction before starting work. This included training identified as necessary for the service and familiarisation with the organisation's policies and procedures. We saw that the induction programme for new staff included fire procedures, health and safety, safeguarding, moving and handling, equality and diversity, Mental Capacity Act, medicines and privacy and dignity. The induction was in line with the Care Certificate which is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone. Staff told us they had completed, or were working towards completing the care certificate and had shadowed other workers before they started to work on their own.

Staff received support from the management team in the form of supervision and annual appraisals. They told us they felt well supported by the management and were able to ask for additional support if they needed it. Staff meetings were held to provide staff with an opportunity to share information and voice any ideas or concerns regarding the running of the service. Daily meetings took place with the heads of each staff team to sharing information.

Staff demonstrated a good knowledge of people's needs and told us how they cared for each individual to ensure they received effective care and support.

People told us they did not feel they had been subject to any discrimination, for example on the grounds of their gender, race, sexuality or age. The service had an equality and diversity policy in place. People told us, "Most of them (staff) are very well trained. But they are busy people, they have to go to other people," "They're kind, that's their skill. It's never 'I can't be bothered."

People's view of the food was varied, comments included, "It's very good. They come before and say for lunch it's so and so. They know I don't like rice pudding or offal. I say, 'No offal', they're alright with that," "On the whole (its good). One meal I particularly like is gammon with pineapple. I've had that fortnightly" and "The meals aren't nice. They're not cooked properly. I had a casserole and I couldn't eat any of the meat, it was so tough. Rice pudding comes round too soon, well that's what it was, it's ice cream all the time now. The chef left (I rather believe several people left at the same time) so they're struggling. The deputy chef has had to step up" and "It's eatable. It's not always cooked the way you'd like it. It's not their fault. I have the fish, they can't do wrong with that. Saying that, I had poached haddock and it was so overcooked it couldn't eat any of the haddock." The catering staff consulted with people regularly about the food and wrote comments down in a book. This helped inform future meal choices.

We observed the lunch being served to people in the dining area. Most people could eat independently. Those requiring help were asked for their consent before food was cut for them. Those who needed assistance to eat were supported in an unhurried manner and were asked what they wanted to eat next. For example, we heard a member of staff ask someone, "Would you like some potato now ?". One person remarked she had not been given the meal she'd ordered and was reassured this was not a problem and was brought the second option. Another person, on being asked if everything was satisfactory, complained she was given only two small pieces of chicken and was offered more food. Two people were seen waiting at their table for nearly an hour before the meal. Both people sat in their wheelchairs for their lunch and ate

with difficulty, stopped eating for periods and both went to sleep on occasion during the meal. There was a lack of support for these people to assist them to finish their meal while it was hot.

We recommend the service review the staff support provided to people during meals to ensure people get the assistance they require.

No one was having their food and drink intake monitored at the time of this inspection. The deputy manager monitored people's weight regularly to ensure they had sufficient food. Staff regularly consulted with people on what type of food they preferred and ensured that food was available to meet peoples' diverse needs. The minutes of a residents meeting showed people had asked for portions to be more consistent and for certain foods to be provided. This had been done which showed the service listened to people's views. The kitchen recorded the views from people about the food provided at the service and this informed the menu plans.

The service had a good working relationship with the local GP practices and district nursing teams. District nurses were visiting the service daily to see people with nursing needs. Other healthcare professionals visited to see people living at Church Farm when required. We saw people had seen their optician and podiatrist as necessary. The service had identified that communication with visiting healthcare professionals could be better. As a result of this a member of staff always met with the healthcare professional and took them to the person they wished to see. This had helped communication because staff were able to explain more about the person rather than the professional just relying on notes. A record was then made about the outcome of the visit and any actions required.

People were encouraged to be involved in their own healthcare management. People were supported to be independent in their own medicines administration with staff checking on their competencies regularly. Some people came in for a short stay and they were encouraged to continue to manage their own medicines as they did at home. When people were visiting hospital the service ensured that people's medicines travelled with them along with a summary of their care plan.

The service was well maintained, with a good standard of décor and carpeting. Some people living at Church Farm were living with some cognitive impairment and were independently mobile around the building. They required additional support to recognise their surroundings. There was no pictorial signage which clearly identified specific rooms such as toilets and shower rooms. People's bedrooms displayed a number and a small name plate displaying their name in small print. This was not easy to read for people with poor sight and did not help people with an impairment to find and recognise their own room independently. The management team told us such support was provided on a case by case basis as needed.

Good

Is the service caring?

Our findings

People and their relatives were positive about the attitudes of the staff and management towards them. People were treated with kindness, respect and compassion. Comments included, "Nothing is too much trouble. They do have to rush off if they're busy," "They're friendly and I think of them as friends," "They are very helpful, very kind and friendly. You couldn't ask for more." People got to know the staff well. Some people commented they had experienced difficulty in understanding staff when English was not their first language.

Staff had time to sit and chat with people. We saw many positive interactions between staff and people living at Church Farm. Relatives and healthcare professionals told us staff and the management were kind and caring. One person became anxious, in the corridor, and asked staff to help them. This was done quickly with no fuss and lots of patience. Their care plan gave clear guidance to staff on how to respond when they became anxious. Staff knew this person well.

People told us staff always asked them before providing any care and support and if they were happy for them to go ahead. People were encouraged to make decisions about their care, for example what they wished to wear, what they wanted to eat and how they wanted to spend their time. Where possible staff involved people in their own care plans and reviews. However, due to people's capacity involvement this was often limited, and consultation could only occur with people's representatives such as their relatives. Families told us they were informed by the service of any changes in people's condition.

People's dignity and privacy was respected. For example, one person preferred only to be cared for by female carers and this was respected. Staff provided people with privacy during personal care and support ensuring doors and curtains were closed. If people required the use of moving and handling slings these were provided, named solely for their use and not shared. Staff were seen providing care in an un-rushed way, providing explanations to people before providing them with support and ensuring they were calm throughout.

During the day of the inspection we spent time in the communal areas of the service. Throughout the inspection people were comfortable in their surroundings with no signs of agitation or stress. Staff were kind, respectful and spoke with people considerately. We saw relationships between people were relaxed and friendly and there were easy conversations and laughter heard throughout the service.

When people came to live at the service, the manager and staff asked people and their families about their past life and experiences. This way staff could have information about people's lives before they lived at the service. This is important as it helps care staff gain an understanding of what has made the person who they are today. Information in care plans about people's past lives was variable. However, staff did help to complete this information with people if they were able to participate in this exercise. Staff were able to tell us about people's backgrounds and past lives. They spoke about people respectfully and fondly. Comments from people and families included, "I think the girls are extremely kind. Very gentle and very kind,'' "They're friendly, they do their best,"

"Staff are so kind to people. If people aren't up to scratch, they get such tender help," "They (staff) are wonderful, incredible. They can't do enough, they are so kind" and "They're helpful and pleasant and good fun. They have an open minded point of view. If you ask for something, they respond."

Care files and information related to people who used the service was stored securely and accessible by staff when needed. This meant people's confidential information was protected appropriately in accordance with data protection guidelines.

The service had held residents meetings which provided people with an opportunity to raise any ideas or concerns they may have. Meetings were held at different times of the day and different days of the week to enable as many family members to attend as possible. Any issues identified at these meetings were addressed. For example, it had been identified that a wider wheelchair access via the front door was required and this was in the plan for future refurbishment work at the service. One person told us, "I don't have any significant criticism. I would say the grounds aren't very attractive. I would like to have more opportunity to go out."

Bedrooms were decorated and furnished to reflect people's personal tastes. People were encouraged to have things they felt were particularly important to them and reminiscent of their past around them in their rooms. There were cats and a budgie living at the service. People were seen to greatly enjoy their company.

Visitors told us they visited regularly at different times and were always greeted by staff who were able to speak with them about their family member knowledgeably. People were well cared for. Some women wore jewellery and make up and had their nails painted.

Good

Is the service responsive?

Our findings

Some people had been assessed as requiring specialist equipment to protect them from the risk of developing pressure damage to their skin. When the service identified the need for an air filled pressure relieving mattresses this was provided by the district nursing service. Two were in use at the time of this inspection. One person had required pressure relieving equipment to heal a pressure sore. Once this had healed the specialist equipment had been removed from the service. This person developed a further pressure sore and again required specialist equipment to be provided. The service did not have their own equipment and whilst the person had the use of this equipment at the time of this inspection, there had been some delay in the equipment being bought in to the service. This concern was the subject of a safeguarding investigation at the time of this inspection.

There was one person who required re-positioning while being cared for in bed. This monitoring was in the process of being set up by the district nurses with the staff at the time of this inspection.

People told us they felt involved in their own care and the running of the service. Some people recalled being asked about their care plans. Families were confident that they could access any information relating to the care of their family member if required.

People and their relatives were positive about living at Church Farm and the staff and the management team. Residents meetings were held where views and experiences were sought. However the relatives we spoke with had not attended any of these meetings.

People who wished to move into the service had their needs assessed to ensure the service was able to meet their needs and expectations. The deputy manager was knowledgeable about people's needs. Each person had a care plan that was tailored to meet their individual needs. Care plans contained information on a range of aspects of people's support needs including mobility, communication, nutrition and hydration and health. Care plans were regularly reviewed.

Daily notes were consistently completed and enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being. People had their health monitored to help ensure staff would be quickly aware if there was any decline in people's health which might necessitate a change in how their care was delivered. This meant people's changing needs were met but this was not always recorded in the care plans. One person had deteriorated rapidly in the days prior to this inspection. Their care plan had not been updated to take account of these changes. However, we judged this did not impact on the care provided to this person and staff were meeting the person's needs. The family were very happy with the care provided for this person and how the staff had adapted to the change in their needs.

People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at the service. Staff were able to tell us detailed information about people's current needs as well as their backgrounds and life history from information gathered from people, families and friends.

There was a staff handover meeting at each shift change to exchange any information. Handover information helped ensure there was a consistent approach between different staff and this meant that people's needs were met in an agreed way each time.

An activities co-ordinator worked 30 hours per week and the service, with a further recently appointed deputy who will work for 20 hours per week. Activities were provided at weekends when there were more opportunities to involve families. There was a programme displayed for people advertising exercises, quizzes, music and magic shows. People told us, "They have, for instance, a war film coming. I'm looking forward to that. If I have to go to the main hall, a wheelchair is whistled up very quickly," "(Person's name) used to be very sociable, but not now. They always bring the activities calendar, but she chooses not to go," "No, I'm content to watch TV and watch the world go by," "We've been to the activity this morning, a Scottish thing. It was quite enjoyable." People told us they had two activities each day. There was bingo every week, that attracted a lot of people. There was a shopping trolley with basic goods like toothpaste for people to buy what they wished. External entertainers visited the service regularly.

The activities co-ordinator asked people what they would like to do and monitored how successful each event was and asked for feedback informally. Records of activities attended were seen in people's care plans. The activities coordinator was extremely enthusiastic, constantly looking out for new activities to provide. They knew people and their likes and dislikes and seemed very responsive to ideas from them. Everyone was involved in something, although not necessarily on a weekly basis.

Some people chose not to take part in organised activities and therefore could be at risk of becoming isolated. During the inspection we saw some people either chose to remain in their rooms or were confined to bed because of their health needs. Activities were provided on a one to one basis to people in their rooms. Ladies could have their nails painted if wished. We saw staff checked on people and responded promptly to any call bells.

Some people were unable to easily access written information due to their healthcare needs. Staff supported people to receive information and make choices where possible. Menu choices were requested from people each day for the next days meals. Staff were seen sitting with people going through the menu to help people to make a choice.

People were supported by staff to maintain their personal relationships. This was based on staff understanding who was important to the person, their life history, their cultural background and their sexual orientation. Visitors were always made welcome and were able to visit at any time. Staff were seen greeting visitors throughout the inspection and chatting knowledgeably to them about their family member. Relatives were able to join their family members for meals if they wished. Relatives comments included, "I'm always welcomed, definitely. A lot of the staff I see quite regularly. Several have been here quite a while. That's a very good thing," "Visitors are always offered a drink. They come along with a tray and a white cloth. They look very grand, the men from the kitchen, in their whites."

People and families were provided with information on how to raise any concerns they may have. Details of the complaints procedure were contained in the complaints policy. People told us they had not had any reason to complain. We saw concerns that had been raised to the manager had been investigated fully and responded to in an appropriate time frame. All were resolved at the time of this inspection.

People were supported at the end of their lives to have a comfortable, dignified and pain free death. The service had arranged for medicines to be held at the service to be used if necessary to keep people comfortable. Where appropriate people had an end of life care plan which outlined their preferences and

choices for their end of life care. However, we did not see many details completed in this section of the care plans we reviewed. The deputy manager told us there were good links with GP's and the district nursing service to ensure people received suitable medical care during this period of their lives.

Good

Is the service well-led?

Our findings

People, relatives and staff told us the registered manager was approachable and friendly. They told us, "Last time I was here, she was walking past and she popped in. That's the good thing about having her door open, people pop in," "I class her the same as the rest of the staff, she's very helpful and friendly. She always lends an ear when I want to speak" and "I've known her for about 20 years, she can't do enough for us."

The service is required to have a registered manager. 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. The service had a registered manager in post.

The registered manager spent time within the service so was aware of day to day issues. The manager believed it was important to make themselves available so staff could talk with them, and to be accessible to them. Staff met regularly with the registered manager, both informally and formally to discuss any problems and issues. Staff told us they felt well supported through supervision and regular staff meetings.

Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service was notifying CQC of any incidents as required, for example expected and unexpected deaths. The previous rating issued by CQC was displayed.

There was a clear vision and strategy to deliver high quality care and support. There were clear lines of accountability and responsibility both within the service and at provider level. There was a clear management structure. The registered manager was supported by a deputy manager who provided us with all the information we required on the day of this inspection.

There were systems in place to support all staff. Staff meetings took place regularly. These were an opportunity to keep staff informed of any operational changes. They also gave an opportunity for staff to voice their opinions or concerns regarding any changes. Team leaders also had daily meetings every morning to help ensure communication throughout the service was effective.

The provider had a quality assurance policy. People, their relatives and staff had recently been given a survey to ask for their views on the service provided at Church Farm. Responses were positive including, "If you have to go into a home best to go to a reputable one, no complaints" and "I am happy here." The service displayed an 'Openness statement' on the notice board, stating they were open to any comments. There was a robust system of audits to ensure quality in all areas of the service was checked, maintained, and where necessary improved. Audits regularly completed included monitoring care plans were to a good standard and regularly reviewed, monitoring accidents and incidents, medicines systems and checking property standards were to a good standard. The results of all the audits fed in to a Home Improvement Plan. This set out plans and vision for the future of the service such as the provision of wet rooms and landscaping the grounds.

The provider visited the service regularly to support the management team. Two representatives of the provider were present at the end of this inspection visit.

Lessons were learned from events, any comments received both positive and negative we seen as an opportunity to constantly improve the service provided. The management team and the provider representatives accepted that the concerns found at this inspection were a fair judgement of the service at this time. Some of this issues we identified had been recognised by the service and they were in the process of addressing them.

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. Staff and visiting healthcare professionals had access to records to help ensure the care plans were kept up to date with changing situations.

There were staff with the responsibility for the maintenance and auditing of the premises. Equipment such as moving and handling aids and lifts were regularly serviced to ensure they were safe to use. The environment was clean and well maintained. People's rooms and bathrooms were kept clean. The maintenance staff carried out regular repairs and maintenance work to the premises as required. Staff used a faults book to record any issue that needed attention, these were signed off as completed. The boiler, electrics, gas appliances and water supply had been tested to ensure they were safe to use.