Care Quality Commission

Brookholme Croft Ltd

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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 inspection was unannounced and took place on the 3 April 2017. It was the first inspection following our registration of this provider under the Health and Social Care Act in March 2017.

Brookholme Croft Ltd provides accommodation, nursing and personal care for up to 45 older adults. This may include car for people living with dementia, physical disability or people who are receiving end of life care. At the time of our visit, there were 44 people, including 24 people receiving nursing care at the service. There was a registered manager at this 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 were safety supported in a clean, safe and well maintained environment. Any equipment used for people's care was routinely serviced and maintained up to date. Planning and contingency arrangements helped to ensure people's safety in the event of a foreseeable emergency.

Arrangements for cleanliness, hygiene and infection prevention and control helped to prevent and reduce any risk to people from an acquired infection through cross contamination.

People's medicines were safely managed. Known risks to people's safety from their health condition or environment were assessed before they received care and regularly reviewed. This helped to consistently inform people's care and related safety requirements, which staff followed.

The provider's arrangements for staff recruitment and deployment helped to ensure people were protected from the risk of harm and abuse

People's health and nutritional needs were being met. People were supported to improve and maintain their health and nutrition by staff who sought and followed advice from relevant external health professionals when required.

People's care was provided in a way that met their assessed need by staff who were qualified, trained and supported to help ensure this.

People were provided with care in line with legislation and guidance in relation to consent. People's consent or appropriate authorisation was obtained when required for people's care.

People received care from staff who were kind and caring. Staff treated people with respect and ensured their dignity, comfort, rights and independence in their care.

Staff knew people well; what was important to them for their care and had established positive relationships

with people and their relatives.

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People and relatives were mostly well informed and involved to understand and agree people's care. Management assurance was provided to ensure people's care plans consistently showed their involvement.

Staff were visible, observant and provided people's care in timely and individualised way. Staff communicated well with people in a way they understood, which helped to ensure people's choice and independence.

Staff understood and followed people's known preferred daily living routines. People were informed and supported to maintain contacts with friend and family who were important to them.

Arrangements for people's occupation, leisure and spiritual practice were driven by people's known lifestyle preferences and interests. This was provided in a way that helped to promote people's social inclusion and their physical and emotional health.

People, relatives and staff were informed and confident to raise any concerns about people's care or make a complaint if they needed to.

People, relatives and staffs views were regularly sought and used to inform and make improvement to people's care when required.

The service was well managed and run by a visible, approachable registered manager. People, relatives and staff were confident about this.

Staff understood their roles and responsibilities and they were informed and supported to raise any concerns they may have about people's care if they needed to.

Management arrangements for care and service monitoring, communication, record keeping and reporting helped to ensure accountability and continuous improvement for the quality and safety of people's care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People felt safe and were protected from the risk of harm or abuse. Staffing and care planning arrangement helped to ensure people received safe care and treatment. People's medicines were safely managed. The environment and equipment used for people's care was kept clean, hygienic and well maintained.

Is the service effective?

Good

The service was effective. People were supported to maintain and improve their health and nutrition. Staff consulted with relevant external health professionals when needed to help ensure this. Staff followed the law to obtain people's consent, or appropriate authorisation for their care, or to provide care in people's best interests when required. Staff were qualified, trained and supported to ensure people's nursing and personal care needs could be met.

Is the service caring?

Good

The service was caring. People were treated with kindness and respect by staff who promoted their dignity, rights and independence. Staff had established good relationships with people and relatives who were mostly well informed and involved in agreeing care to be provided. Management assurance was given to ensure this was consistently shown in people's written care plans.

Is the service responsive?

Good

The service was responsive. People received timely, individualised care from staff and were supported maintain contacts with family and friends. Staff knew and communicated well with people, which helped to ensure their comfort, choice and independence. People's social inclusion and their lifestyle interests and preferences were promoted. People and relative's views, compliments and complaints were sought and used to help inform and improve people's care when required.

Is the service well-led?

Good

The service was well led. People, relatives and staff were

confident in the management and running of the service. Staff understood their roles and responsibilities for people's care. Management procedures and care assurance measures helped to ensure accountability and continuous improvement for the quality and safety people's care.

Care Quality Commission

Brookholme Croft Ltd

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.

We visited the Brookholme Croft Ltd on 3 April 2017. Our visit was unannounced and the inspection team consisted of two inspectors, a specialist advisor with experience of dementia care 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 service.

Before this 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. We also spoke with local community professionals and care commissioners and looked at all of the key information we held about the service. This included written notifications about changes, events or incidents that providers must tell us about.

During our inspection we spoke with six people who lived at the home and seven relatives. We spoke with three nurses, including the registered and deputy manager; a cook and four care staff, including one senior and an activities co-ordinator. We also spoke with the registered provider. We looked at seven people's care records and other records relating to how the home was managed. For example, medicines records, meeting minutes and checks of quality and safety.

As some people were living with dementia at the service, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Good

Is the service safe?

Our findings

People and most relatives were confident people were provided with care that helped to keep them safe at the service. One person said they felt safe, "Because staff are constantly around.'" Their relative told us, "Staff check he is alright; they let me know when he had a fall; there is an electronic sensor in place now in the bedroom to alert staff to his movement; I feel he's safe and well looked after."

Most people and relatives felt there were enough staff and that staff usually responded in timely manner when people needed assistance. However, there were some mixed views. For example, two people's relatives said they were recently concerned with staff monitoring arrangements for people in lounge areas. This related to known risks to people's safety from falls because of their health conditions. During our inspection we observed staff were visible and available when people needed them and they supported people safely. This included supporting people with their mobility and medicines. People's care plan records showed that known risks to people's safety were identified before they received care. Staff followed people's written care plans, which showed how those risks were being managed and reviewed. For example risks from falls, pressure sores, poor nutrition and infection.

Management and staffing arrangements were sufficient to ensure people's safety. Staff described appropriate arrangements for their recruitment and deployment, which related records showed. Rotas were flexible to provide additional staffing at key times. For example when the deputy nurse manager was supporting external health professional reviews of people's care at the service and therefore not deployed to provide people's care then.

Management records and staff rotas showed that people's care and dependency needs were regularly reviewed and taken into account to help inform staff skill mix and deployment. Staffing arrangements had been recently revised and increased when required in response to this, staffs' views, concerns and peoples' identified care requirements. Accidents and incidents, such as falls and injuries were regularly monitored to check for trends and patterns. This information was used to help inform people's care and related staffing arrangements. This helped to make sure that people received the care they needed from staff who were safely recruited and deployed.

We saw the premises were clean, safe and well maintained with no malodours. Staff were provided with personal protective clothing, such as gloves and apron which they used to provide people's personal care. Regular management checks were made of cleanliness, hygiene and infection control arrangements to ensure they met with recognised national guidance for this. This included instruction and periodic checks of staff hand hygiene. Records of recent checks showed satisfactory arrangements with two areas where minor improvements needed were identified and planned. The registered manager had notified us of an important event which stopped the service when required following an outbreak of a virus infection. This showed that correct procedures were being followed to control the spread of infection; which included the home being closed to visitors for a period of time. This helped to prevent and reduce any risk to people from an acquired infection through cross contamination.

Records of the servicing and maintenance of equipment use for people's care showed this was up to date for safe use. Emergency plans were in place for staff to follow in the event of any emergency in the home. For example in the event of a fire alarm. Routine fire safety checks and staff fire drills were being regularly undertaken and recorded. The provider's fire safety risk assessment had been recently reviewed in accordance with Derbyshire Fire and Rescue Services last fire safety inspection of the home in May 16 and showed fire safety matters at the service were satisfactory. This helped to ensure people's safety at the service.

Information was displayed, which informed people about what to do if they witnessed or suspected the abuse of any person receiving care at the home. Staff knew how to recognise and report abuse and they were provided with regular training and appropriate procedures to follow in any event. This helped to protect people from the risk of harm and abuse.

People's medicines were mostly safely managed. However, important stock checks required for certain medicines were not always completely followed by staff responsible; or fully shown in the provider's related policy guidance for staff. This meant there was an increased risk of misuse of those medicines. We also found that administration records for some people's topical administration records were not consistently recorded, which meant they did not always show whether people's skin creams had been given to them as prescribed. We discussed our findings with the registered manager who has confirmed their actions to reduce the risk from this.

People we spoke with said they received their medicines when they needed them. One person said, "Yes, I have it in a morning and at night time; they are very good, it's always on time". A relative said, "Medicines were a big safety problem when they [person receiving care] were at home; Staff here look after all that properly and make sure it's right and given on time." Another relative told us, their family member needed regular medication for their [identified health condition] and said "It's quite critical that they are given at certain times and they see to that."

We observed staff giving some people their medicines and saw that this was being done safely. For example, one person was prescribed medicines, which were given to them regularly and a pain relief medicine, to be given at the times they needed it. At lunchtime we observed that, staff took the person's regular medicines to them. They took time to check with the person if they needed any of their pain relief medication and the reason for this. This helped to make sure the person received their medicines safely and for the reason they were prescribed.

Staff told us about some people living with dementia, whose medicines were prescribed to be given when they needed them rather than at regular intervals but who could not always say when they needed them. For example, medicines for their pain relief. Clearly written up to date care plan protocols were in place for this, which staff understood and followed to help ensure people received their medicines consistently when they needed them.

Staff told us about some people living with dementia who sometimes needed their medicines to be given covertly to keep them safe. Covert medication refers to medication that is hidden in food or beverages. Staff explained that because of the person's health condition, they sometimes refused their medicines and didn't always recognise them as important for their physical health. Staff, were able to describe a consistent approach to support people to take their medicines. This was done in a way that helped to minimise the need for the medicines to be given covertly, which was shown in each person's related written care plan protocol. For example, one persons' medicines administration record (MARs) showed that this approach was working because they usually accepted their medicines when they were offered to them. Care plan

protocols were agreed consultation with relevant health professionals and relatives who knew people well. This helped to ensure people's safety and best interests.

All nursing and care staff responsible for people's medicines told us they received training for this to an advanced level, which also included an assessment of their competency to administer people's medicines. Staff training records reflected this and showed that staff received relevant updates or refresher training when required.

Good

Is the service effective?

Our findings

People were supported to improve and maintain their health and nutrition. People and relatives were happy with the care provided. Results from the provider's recent questionnaire survey with them showed people's care was rated as either good or excellent. People and relatives we spoke with felt staff understood people's health needs and their related care requirements. They also told us staff were observant to any changes in people's health and ensured their timely support to access external health professionals when required. One person told us, "The doctor comes when needed; staff arranged for my eye appointment at the hospital." Another person said, "They've done my nails today; a chiropodist domes to do my feet regularly."

A relative told us about staff's care which led to improvement in their family members health. The relative made particular reference to the 'awful bed sores they had before they came here' and said, "Staff have cleared them up by keeping her skin clean and treating them properly." The person's related care plan records we looked at showed staff followed instructions from relevant external health professionals and nationally recognised guidance concerned with wound care to help ensure this. This relative also told us how staff arranged for their family member's foot care, eye and dental checks following their admission, which also helped to improve their related health.

Other people and relatives told us that staff acted promptly to seek medical advice and also to inform relatives following any changes in people's health needs. One person' relative told us they were very happy with the care provided and said, "[Family member] is being look after; they are prone to infection, which can knock them down quickly; staff pick up on it and get the doctor straight away." Another said, "Staff are organised and very good; they got the out of hours doctor when needed; organised hospital transport and let us know straight away; they also sort routine health appointments and transport as well."

People's care plans provided comprehensive information about people's health conditions and their related personal care needs and requirements, which staff understood and followed. Care plans were regularly reviewed and updated when required. For example, following any changes in people's health or instructions from external health professionals concerned with people's care. This helped to ensure a consistent and informed approach to people's care.

People received care from a multi-disciplinary staff team, who were trained and supported to perform their role and responsibilities. For example, this included registered nurses, care staff, an occupational therapist and a physiotherapist. Staff told us they received the training, support and supervision they needed to provide people's care. Records reflected this and showed staff received regular training updates, bespoke training and relevant competency assessments to ensure their knowledge and understanding.

One care staff member said, "We have a good level training and support here; there is a rolling programme for all core training and additional training about people's individual health conditions." Examples they gave included Parkinson's disease, diabetes, dementia and delirium. Further training was planned in relation to positive behaviour support and least restrictive care interventions for people who may sometimes behave in way that was challenging to others.

Nurses employed at the service were supported to undertake extended role training such as urinary catheterisation or venepuncture training for taking blood samples. Relevant, higher level training was also provided for nurses and care staff who had identified lead roles for people's care. For example, in relation to people's nutrition, medicines, end of life care or moving and positioning requirements.

Care staff, were supported to achieved a recognised vocational care qualification above minimum level requirements to help advance their skills and knowledge in health and social care. Arrangements were in place to introduce the Care Certificate for all care staff working at the service. The Certificate builds on existing induction and training standards. It is a recognised attempt to set a minimum level of training for all care workers and health care assistants. It aims to make sure that non-regulated care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. This helped to make sure people received care based on recognised practice, which met their needs and was delivered by staff that were appropriately trained and supported.

People and their relatives told us that sufficient nutritious meals were provided along with regular snacks and drinks. All thought the quality of the food was good but with mixed views regarding the choice and variety of meals. One person said, "The meals are alright; some days better than others; We've all go different tastes; there's a choice of two meals but if you don't want either they will do you something else – they are very good like that." Another said, "Meals are plenty but could be better; sandwiches every day for tea." One person's relative said, "They don't always asked him what he wants; I don't think they explain enough to people what the meals are; The meals are very good though and quite large."

When we spoke with the cook we were told that the first time people knew what their choices were for lunch; was when they sat down and saw the menu on the table. At lunchtime we also saw that people were asked for their meal choice before their meals were served to them. We discussed our findings with the registered manager who agreed to take the required action to address people's expressed views about meals in relation to variety, choice and involvement. This included a care survey with them and their relatives, to help inform this.

Lunchtime was relaxed and sociable. Meals were served to people seated in two dining rooms or in their own rooms, if they chose. Tables were appropriately set and people were asked where they wished to be seated. Staff knew people's likes and dislikes, offered a choice of drinks and meals from the daily menu and the use of protective aprons or napkins. Staff also checked people's meal choice with them before setting it on the table and were observant and checked with people if they needed assistance. Healthy eating and hydration was promoted. Healthy snacks and drinks were readily available with appropriate facilities provided in communal areas; to enable people to help themselves to cold drinks as they wished. Following the success of "Smoothie Tuesday" during a nutritional promotion week; fruit smoothies were made regularly available for people.

Some people had difficulties eating and drinking because of their health conditions. This included some people who had swallowing difficulties, which meant they may be at risk of choking. We observed that staff gave people the support they needed to eat and drink. They served different types and consistencies of foods to people, that met with their dietary requirements and related instructions from relevant health professionals. People were also provided with adapted eating utensils to help them to eat and drink independently when required.

People were provided with care in line with legislation and guidance in relation to consent. 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. 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.

We checked whether the service was working within the principles of the MCA. Staff had received training and they understood the basic principles of the MCA. During our inspection we observed where possible, staff sought people's consent to their care; they offered choices and explained what they were going to do before they provided people's care. People were not always able to consent to their care or make important decisions about their care and treatment because of their health conditions. People's care plans showed an assessment of their mental capacity and any specific decisions about their care and treatment to be provided in their best interests. However, the best interests' decisions about people's care were identified by a tick box approach from a standard list of care needs. This list was kept in a separate section of the care file with no identifiable link to people's related best interest care plans, which were provided elsewhere for staff to follow. This did not best inform staff to fully ensure people received care agreed in their best interests because it was difficult to follow. However, staff were each able accurately describe care to be provided in people's best interests when we asked them. We discussed our findings with the registered manager who agreed to take the action required to reduce the risk of ineffective or inappropriate care provision from this.

With the exception of one person; people's care plans, relating to best interests decisions for their care, showed appropriate consultation with their relative and any relevant health professionals to help inform and ensure this. This included relevant information where people had others who were legally appointed to act or make important decisions on their behalf; in relation to their health and welfare and/or finances. Following our inspection the registered manager told us about the required action they had taken to fully ensure this.

Staff told us about some people whose care needed to be provided in a way that that continuously restricted their freedom but was necessary to keep them safe. This is known as a Deprivation of Liberty Safeguard (DoLS). Records showed the DoLS were either formally authorised or requested from the relevant local authority where required. This helped to ensure people's rights and best interests in their care.

Good

Is the service caring?

Our findings

People and relatives said staff were kind, caring; ensured people's dignity and privacy and treated them with respect at all times. We received many positive comments from them about this. One person said, "Staff are caring, friendly and respectful; I couldn't ask for more." Another person told us, "They draw the curtains and shut the door when they are dealing with me." A relative said, "Staff are very good in the way they approach people; they always try to keep my [family member] independent; ask for permission and explain what they'd like my [family member] to do; they never tell [family member].

People's care plans we looked at showed people's known choices and preferences for their care, which staff understood and mostly followed. For example, in relation to their daily living routines and lifestyle preference, likes and dislikes. However, people told us that meal choices were not always explained or ensured. We also found people's care plans often did not show how people's known choices and preferences were obtained. This meant people's level of involvement in agreeing their care plan and also relatives' involvement were not clearly identified. We discussed our findings with the registered manager who has since told us about their actions to address this.

Throughout our inspection we observed that staff, were kind and caring, treated people with respect and ensured their privacy and independence. They offered and followed people's choices when they provided care. For example, where to sit, how to spend their time and what to eat and drink. Staff, received training and were aware of the provider's aims and values for people's care, which they followed to help ensure people's rights. For example, their rights to dignity, choice, independence and respect.

We saw that staff supported people in a caring, sensitive and timely manner when they needed assistance. They also encouraged people to do as for themselves as much they were able and wished to do so. For example, supporting people with their mobility, medicines, meals and drinks. Staff made sure people had equipment and personal items to hand if the needed them; such as walking frames, call bells, drinks and personal items.

Some people were not able to talk with staff because of their health conditions. We saw that staff knew people well and followed their known daily living preferences, routines and choices, which were recorded in their care plans. For example, staff told us about one person living with dementia who could sometimes become distressed in busy communal areas if they didn't understand where they were or what was happening around them. Staff knew the person found particular comfort from their distress in a personal doll and we saw they made sure the person had this to hand when they were in the communal lounge area. Staff also took time in quiet caring manner to explain to the person where they were and what was happening, which supported the person to remain calm. This care helped to promote people's dignity, comfort and independence.

People and relatives had good relationships with staff who knew them well but were not always fully involved in agreeing their care. One person said, "Staff are so good with everyone; it's their general approach; some have plenty of fun with us." Some people and relatives felt somewhat informed in relation

to people's care plans; others felt they were not fully involved at all. One person's relative said, "We have sat with the manager and social worker and we got an independent advocate at one stage." However, other comments made by people in relation to this included, "I have seen my care plan but have had no part in agreeing it; and "I have seen it [care plan] and had two conversations where I was told about it; but haven't had any involvement in putting it together."

Regular opportunities were provided for people's comfort, spiritual and emotional support. This included sensory therapies such as hand massage and music therapy. There were regular opportunities for people to practice their faith within the home and also the local community where people were supported to access relevant buildings for their chosen spiritual worship.

A range of key service information was provided to help inform people's care. For example, this included how people should expect to be treated by staff and arrangements for occupation and leisure, meals and laundry. It also included how to access independent advocacy services if people needed someone to speak up on their behalf.

Regular newsletters were provided for people, relatives and staff to help inform and promote their inclusion in home life. Management advised that key information could be made available in other languages or other alternative formats to aid people's understanding if required. For example, large print or easy read pictorial formats. We saw some of this was displayed in prominent places where people could see it easily. Such as pictorial information for people about social and recreational activities they could join. Photographs of staff were also shown with their names to help people know them.

Good

Is the service responsive?

Our findings

Overall, people and relatives were positive about the timeliness of people's care and felt staff were helpful and usually prompt to provide people with assistance and support when they needed it. One person who often spent time in their own room told us, "If I press my call button, staff come within a couple of minutes; I sometimes have to wait for 10 minutes depending on what I want; it's no problem – they have a lot to do." Another person told us, "It varies; sometimes they [staff] come quickly, other times it might take a bit longer but more often you don't have to wait too long."

Throughout our inspection we observed staff were visible, observant and provided people with care and assistance in a timely manner. This was done in a way that promoted people's comfort, independence and inclusion. For example, we heard one person tell a care staff member they were unable to hear properly. The care staff checked and helped to change the hearing aid battery which enabled the person to hear. We saw that staff overheard one person telling another person they were feeling cold; staff checked with them then fetched a cardigan from the person's room for them to wear, which the person was pleased about. We also saw a care staff member taking one person a cup of tea they had asked for. The person was unable to see this as because of their visual impairment. The staff member touched the person gently on the shoulder as they approached the person and explained what they were doing by ensuring the person knew where their drink was positioned on the table in front of them before they left to assist other another person.

Staff communicated well with people in a way they understood. We observed staff understood how to communicate with people who were not able to talk with them because of their health conditions. For example, we saw a care staff member taking round a choice of drinks in the communal lounge area for people who were unable able to help themselves. Some people living with dementia were not able to understand the care staff member when they asked for people's choices. We saw the care staff placed a choice of drinks on the table in front of each person. They then crouched down to the person's eye level and used simple words and gestures to help explain the choices. This was done in a clear patient and respectful manner, which enabled each person to make an independent choice.

People's care plans showed staff how to communicate effectively with people in relation to their care, which we saw staff understood and followed. For example, staff told us about one person who could sometimes behave in a way that was challenging for others because of their health condition. This meant, that person could easily become distressed or upset if they didn't understand what was happening around them or when staff needed to provide their care. We saw that all of the person's care plans included information for staff about how to communicate with the person effectively to help prevent or reduce their distress. For example, to help the person to take their medicines or to wash or dress. This helped to ensure individualised care by meaningful communication.

People were informed and supported to engage in a range of social and recreational activities and maintain their contacts with family and friends who were important to them. People and relatives described the home as 'like a family' and 'open and welcoming.' One relative said, "I can visit any time [person] wishes, I'm always made welcome."

People said social and recreational activities were regularly organised within and outside the home, which they could join as they choose. One person said they particularly enjoyed a regular game of dominoes and we saw staff supported them to do so within a small group of peers; with lots of friendly chatting and banter, which they said they enjoyed. Another person told us they enjoyed arm chair exercises to music, which we saw them engage in during our inspection. One person told us, "If you like to stay in your room; they still include you." The person's relative said, "Staff bring quizzes and crosswords to [the person]." Another relative said, "[Person] takes part in the activities, apparently [person] likes to lead the singing; likes the quizzes and ball games …here there's always stimulation or someone walking past, someone to talk to; [person's] mental health has improved enormously. Another said, "The activities co-ordinator is good; they have quizzes, indoor bowls, painting and sewing; if they telly is on and no one's interested they do something else – put music on - people become more alive."

The home employed an activities co-ordinator who was a registered occupational therapist. They told us that many activities and events provided were driven by people's known preferences and requests. Records showed that regular meetings were held with people, which included discussions about activities and trips out. They also showed that activities were planned and provided to help people maintain their lifestyle interests and preferences but also for their physical and emotional health such as to aid their memory, cognitive recognition and motor skills for their mobility. For example, puzzles, quizzes, exercise and movement and reminiscence through the use pictures, objects and music. Information was visibly displayed for people around the home to help inform them about the arrangements for this, including large print and picture format.

People told us about some of the ways staff supported their preferred daily living routines and choices. For example, in relation to bathing and showering, rising and retiring preferences and times and also to help people to choose their clothing for the day. People's care records also showed they were consulted about their preferences for their personal care staff in relation to male or female care staff.

People, relatives and staff were confident and knew how to raise any concerns they may have in relation to people's care or make a formal complaint. Information about how to make a complaint was visibly displayed. None of the people we spoke with or their relatives had needed to make a formal complaint but said they could and would if they needed to. One relative said, "If I had any concerns I'd speak with the nurse in charge or the manager." One person said, "Staff are easy to talk to; any issues are pretty much dealt with quickly, so they don't get bigger." Records were kept by the registered manager about any complaints received. This showed one anonymous complaint since the provider's registration with us In February 2017. This was investigated and unsubstantiated.

People, relatives and staff were asked for their views about people's care and informed about findings and improvements needed or made from this when required. This included the use of questionnaire type surveys or meetings held with them. Improvements or changes resulted from this, which were either made or in progress. For example, provision of drinks facilities to enable people's independent access; enabling people to access to a mobile dentist; improvements and changes to laundry arrangements, meals and social activities and changes to staffing arrangements.

Good

Is the service well-led?

Our findings

People and their relatives were positive about the management of the home. They knew and understood the roles of staff that led and provided their care and a staff photograph board was displayed, which helped them with this. People and their relatives told us that the registered manager and provider were visible, accessible and approachable. One person said, "The manager is very approachable; always got time for you." A relatives told us, "I know the senior staff; I've spoken with the manager; when I've had little things that concern me she tries to sort them." Another said, "I communicate a lot with the deputy manager; she's very approachable."

The registered manager told us they carried out regular checks of the quality and safety of people's care. This included checks of people's health, nutritional status and related care; medicines and staffing arrangements and checks of the environment and equipment used for people's care. Accidents, incidents and complaints were monitored and analysed to help to identify any trends or patterns. This helped to inform people's care and any improvements needed. Examples of recent care improvements made from this related to staffing, medicines and record keeping arrangements. Management carried out periodic checks of nurses' individual registration status to make sure they were validated to give nursing care. Records also showed a regular provider presence at the service with formal oversight of the management of the home and people's care. This helped to ensure the quality and safety of people's care and continuous service improvement.

Staff understood and followed the provider's aims and values for people's care, which focused on seeking to promote people's involvement, rights, equality and safety. Related training, support and regular checks of care practice helped to promote this. People, relatives and staff were involved in developing and improving the service though regular consultation with them. For example, through meetings and questionnaire type surveys.

Staff were positive about the management of the home and described the registered and deputy manager as, 'approachable,' 'helpful' and 'supportive' and 'fair.' One staff member said, "Management have an open door approach; which is helpful; I have formal supervision and work appraisal; it's very supportive." Another said, "Well supported; we get the support and training we need; all key care information – handovers are very good; thorough."

Care and support staff we spoke with understood their roles and responsibilities for people's care and all confirmed that the provider, senior management and nursing staff were visible and available to them. Records confirmed that staff received supervision and the information and support they needed to provide people's care. For example, communication and reporting procedures were in place to help staff raise concerns or communicate any changes in people's needs. This included procedures to be followed if accidents or serious incidents occurred or if there were any changes in people's health conditions or safety needs. The provider's procedures also included a whistle blowing procedure. Whistle blowing is formally known as making a disclosure in the public interest. This supported and informed staff about their responsibilities and rights to raise concerns about people's care if they needed to.

Records relating to people's care were accurately maintained and securely stored. The provider sent us written notifications about important events that happened in the service when required. For example, to tell us about a person's expected death or an outbreak of infection.