Hexon Limited

Meadowfield Lodge

Inspection report

22 Meadowfield Road
Bridlington
East Yorkshire
YO15 3LD
Tel: 01262 675214

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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

Overall summary

This inspection took place on 22 July 2015 and was unannounced. We previously visited the service on 11 July 2013 and found that the registered provider met the regulations we assessed.

The service is registered to provide personal care and accommodation for up to 24 older people, some of whom may be living with dementia. On the day of the inspection there were 20 people living at the home. The home is located in Bridlington, a seaside town in the East Riding of Yorkshire. It is close to town centre amenities and the sea front, and is on good transport routes.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 3 July 2014. 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.

Summary of findings

People told us that they felt safe living at Meadowfield Lodge and we saw that the premises were being maintained in a safe condition. We found that people were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage issues of a safeguarding nature. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct authorisations had been applied for.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. However, it had been recognised that induction training needed to be more robust to ensure new staff had the skills they needed, and a new induction programme was being introduced. The training record evidenced that most staff had completed training that was considered to be essential by the home.

New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with older people had been employed. We saw that there were sufficient numbers of staff on duty to meet people's individual needs.

Staff that had responsibility for the administration of medication had completed appropriate training. Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust.

People's nutritional needs had been assessed and people told us that their special diets were catered for, and that they were happy with the meals provided at the home. We saw there was a choice available at each mealtime, and that people had been consulted about the choices available on the home's menu.

People told us that staff were caring and this was supported by the relatives and health care professionals who we spoke with.

There were systems in place to seek feedback from people who lived at the home, relatives and staff. There had been no formal complaints made to the home during the previous twelve months but there were systems in place to manage complaints if they were received.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the registered manager were designed to identify any areas of improvement to staff practice that would improve safety and the care provided to people who lived at the home. We saw that, on occasions, the outcome of surveys, audits and complaints were used as a learning opportunity for staff.

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?
The service is safe.

Staff had received training on safeguarding adults from abuse and moving and handling, and the arrangements in place for the management of medicines were robust.

We saw that sufficient numbers of staff were employed to meet the needs of people who lived at the home.

Accidents or incidents were monitored to identify any improvements in practice that might be needed.

Good

Is the service effective?
The service is effective.

We found the provider to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff undertook training that equipped them with the skills they needed to carry out their roles.

People's nutritional needs were assessed and met, and people told us they were happy with the meals provided by the home. People told us they had access to health care professionals when required.

Good

Is the service caring?
The service is caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive relationships between people who lived at the home and staff on the day of the inspection.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

People's individual care needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

Good

Is the service responsive?
The service is responsive to people's needs.

People's care plans recorded information about their previous lifestyle and the people who were important to them, and their preferences and wishes for their care were recorded.

People were able to take part in their chosen activities and their visitors were made welcome at the home.

There was a complaints procedure in place and we were confident that any complaints received by the home would be dealt with in a satisfactory manner.

Good

Summary of findings

Is the service well-led?

Good

The service is well-led.

There was a registered manager at the home who promoted a positive and open atmosphere.

There were sufficient opportunities for people who lived at the home, relatives and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that the systems in place were being followed by staff to ensure the safety and well-being of people who lived and worked at the home.

Meadowfield Lodge

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 22 July 2015 and was unannounced. The inspection team consisted of an adult social care (ASC) inspector 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. The expert-by-experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the registered provider and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they have had with the home. We also contacted a small number of health and social care professionals before the inspection but we did not receive any feedback.

On the day of the inspection we spoke with five people who lived at the home, three members of staff, three visitors / relatives, a visiting health care professional and the registered manager.

We observed the serving of lunch and looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home.

Good

Is the service safe?

Our findings

We spoke with five people who lived at the home and chatted to others. We asked them if they felt safe and they told us that they did. One person said, "I have seen the way staff deal with emergencies – they are brilliant." This view was also supported by the relatives and visitors who we spoke with. One visitor said, "(The person) is safe and full of praise for the staff – she doesn't want to go anywhere else."

We asked staff how they kept people safe. One care worker said, "Walk with them, make sure no obstacles, use wheelchairs and hoists correctly." On the day of the inspection we saw staff using safe moving and handling techniques and that appropriate equipment was used when they assisted people with transfers. The training record evidenced that all staff, apart from one, had completed training on moving and handling.

We also observed that people were able to move around the home without restriction, apart from into the kitchen and laundry areas. There was a code on these doors and the front door to prevent people from entering or leaving the home unnoticed, but we saw that people were supported to go out if they were safe to do so.

We saw that care plans listed the risks associated with each person's care. These included assessments for using a hoist or wheelchair, pressure care, nutrition, choking, falls and the use of Steredent. The level of risk had been identified and risk assessments were reviewed on a regular basis to ensure they were still relevant to the person concerned. However, we saw Steredent in three people's en-suite bathrooms. It was not stored in a cupboard and the bathroom or bedroom doors were not locked, and this could be a choking hazard if it was ingested by someone in error. The registered manager rectified this on the day of the inspection.

We spoke with the local authority safeguarding adult's team prior to the inspection and they told us they had not received any safeguarding alerts from the service or about the service during 2015.

Training records evidenced that most care staff had undertaken training on safeguarding adults

from abuse during 2014 or 2015. Four staff had not completed this training, but the registered manager told us they were currently undertaking a distance learning course on this topic. The staff who we spoke with were able to describe different types of abuse, and they told us that they would report any concerns they became aware of to the registered manager. Staff also told us that they would not hesitate to use the home's whistle blowing policy if they were concerned about incidents or practices at the home.

The registered manager explained the staffing levels at the home; there was one senior care worker and two care workers on duty throughout each day, with two care staff on duty overnight. The registered manager was on duty in addition to care staff on five days a week. There was a cook and one or two domestic assistants on duty over seven days a week. We checked the staff rotas and saw that these staffing levels had been maintained. This meant that care staff were able to concentrate on supporting people who lived at the home and not on domestic or catering duties.

On the day of the inspection we saw that there was always a staff presence in communal areas of the home and that call bells were responded to promptly, although one person told us they sometimes had to wait longer during the night and a relative told us their mum sometimes had to wait for assistance to use the toilet. Other people told us they thought there were enough staff on duty. One person said, "I am satisfied with the staffing. I know if I press the call button they are there quickly."

Records evidenced that the home had a low staff turnover so we were not able to check recruitment records for people who had been employed during the previous few months. We checked the recruitment records for two members of staff who had been recruited in 2013 and 2014. We saw that people submitted an application form that included their employment history, the names of two employment referees, previous relevant training and a declaration about any criminal convictions. We did not see any information to evidence that documents confirming a person's identify had been retained. We saw that two employment references and a Disclosure and Barring Service (DBS) check had been obtained before people started to work at the home. Recruitment records evidenced that only people considered suitable to work with older people had been employed. We noted that new staff had been given a copy of their job description to ensure that they were clear about the role for which they had been employed.

We saw that there was a contingency plan in place and people who lived at the home also had personal

Good

Is the service safe?

emergency evacuation plans (PEEPs) in place. These are documents that record the assistance a person would need to be evacuated from the premises, including the equipment they used to mobilise and the level of assistance they would require from staff.

There were checks in place to ensure that the premises were maintained in a safe condition to protect people's safety. We reviewed a selection of maintenance certificates and saw that there was a current gas safety certificate in place and lifts and hoists had been serviced on a regular basis. Portable electric appliances, the fire alarm system, fire extinguishers and emergency lighting had been serviced in June 2015. The fire risk assessment was updated each week and fire drills had been held in November 2014 and February 2015 to ensure that staff reacted effectively when the fire alarm sounded.

We were concerned that the electrical installation certificate was dated October 2009; the document was incomplete and did not record the date the electrical installation needed to be re-tested. This had been recognised by the registered manager and she had asked the registered provider to arrange for the system to be re-tested. This work was carried out on 23 July 2015 and a copy of the updated certificate was forwarded to the Commission on 29 July 2015.

Some day to day maintenance was carried out by the two handymen employed by the organisation, such as checks on the call bell system, window opening restrictors, water temperature checks and first aid box checks. Staff recorded any repairs that were needed in a maintenance book and the handymen signed the book when they had completed the repairs. We had some minor concerns about storage; the cupboard containing chemicals was not locked and two shower rooms were being used to store small items of furniture. The registered manager assured us that this would be dealt with on the day of the inspection.

We saw the records of accidents and incidents. The records showed that this information was collated and analysed each month to identify any patterns that were emerging or any action that needed to be taken. One entry stated, "(The person) had seven falls this month. The district nurse was called out as (the person) was confused. Antibiotics prescribed due to chest infection." The analysis also recorded whether people who had fallen or had an accident were checked for injuries, and whether any medical attention had been sought. Any injuries or bruises were recorded on body maps so that staff were able to monitor the person's progress.

Staff followed the National Institute for Health and Care Excellence (NICE) guidelines on medication. There was also a good practice procedure in place to ensure the safe administration of Warfarin; people who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered. We saw that senior staff audited medication, including controlled drugs, each month.

Only senior staff administered medication and we saw they had undertaken appropriate training. We observed the administration of medication and saw that this was carried out safely; the senior staff member did not sign MAR charts until they had seen people take their medication, and people were provided with a drink of water so that they could swallow their medication. The registered manager told us that she had also introduced competency checks so that she could monitor staff skills to ensure they remained competent to administer medication; we saw evidence of these in staff files.

There was an audit trail that ensured the medication prescribed by the person's GP was the same as the medication provided by the pharmacy. People told us that they received their medication on time and they did not express concerns about the administration of medication at the home.

Medication was supplied in a bio dose system; this is a monitored dosage system where medication is stored in 'pods' that can be removed individually so that medication can be taken directly to the person concerned. The medication trolley was locked and stored in the medication cupboard. The medication fridge was also stored in the medication cupboard and we saw that the temperature of the cupboard and fridge was taken and recorded each day; the temperatures were consistently within recommended parameters. There was a suitable cabinet in place for the storage of controlled drugs (CDs) and a CD record book. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in use balanced. We checked medication administration record (MAR) charts that were used to record the administration of other medication and noted that there were no gaps in recording and that codes were

Good

Is the service safe?

used appropriately. There were separate charts in people's bedrooms to record the application of creams, and body maps were used to identify where on the body creams needed to be applied. There was a book kept in the medication cupboard where health care professionals recorded any medication updates.

There was an effective stock control system in place and we observed that the date was written on packaging to record when it was opened; this was needed to ensure that medication was not used for longer than stated on the packaging. We checked the records for medicines returned to the pharmacy and saw that these were satisfactory.

We checked the arrangements in place to protect people from the risk of infection. The infection control folder included a list of useful contact numbers, a notice ready to display in the case of an infection outbreak and information about the colour coding of equipment and hand washing. An infection control audit had been carried out each month, and those we saw recorded any actions that were needed and when they had been completed. We had one minor concern; there was no lid on the waste bin in the staff toilet. The registered manager was aware of this and told us that new bins had been ordered.

The laundry room had been divided into 'dirty' and 'clean' areas; it was clear this was known by staff but the provision of signage would confirm this. Mops and buckets were stored appropriately.

Clean laundry was taken straight from the washing machine / dryer and taken to a wardrobe outside the laundry room. This ensured there was minimal contact between clean clothes and dirty areas of the laundry room.

The home had achieved a rating of 5 following a food hygiene inspection undertaken by the Local Authority environmental health department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

Discussion with the registered manager evidenced that she had a clear understanding of the principles of the MCA and DoLS, and we saw that if it was considered that people were being deprived of their liberty, the correct authorisations had been applied for. One person's care plan recorded that a DoLS application had been submitted to the local authority for consideration and had been authorised. This was due for renewal in August 2015 and the registered manager told us that she was in the process of completing this application. We noted that this person had funding for one to one support three times a week so they could access the local community safely.

Training records evidenced that five staff had attended training on MCA and DoLS, and seven members of staff had attended training on dementia awareness; this was considered to be 'optional' training for staff rather than mandatory. Staff were aware of DoLS, how they impacted on people who used the service and how they were used to keep people safe. The staff we spoke with also told us that they did not use any kind of restraint at the home.

The registered manager told us that no-one who lived at the home had a diagnosis of dementia. However, some people were living with a dementia related condition. A person's capacity to make decisions had been assessed and the registered manager told us that best interest meetings would be arranged as needed. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf. One person had a 'Do Not Attempt Resuscitation' (DNAR) form in place and it clearly recorded that they had the capacity to make this decision.

Staff told us that they encouraged people to make choices, such as where to eat their meals, where to spend the day and what activities to take part in. One staff member told us, "We give them options – when they want a shower, what food they want etc." and another member of staff said, "We encourage them to do what they can."

We saw in care plans that people had been asked to sign a document to record their consent to staff administering their medication, taking photographs, sharing information with health and social care professionals and records being kept. People told us that they were consulted about their care and that staff asked for their consent.

We saw the induction records for two members of staff. We noted that these were brief and consisted of an orientation to the home rather than specific training. The registered manager told us that the organisation were in the process of developing a new induction programme that would be adopted by all care homes in the group. This would include new staff completing the Care Certificate; the Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Staff told us they had induction training when they were new in post and that this included shadowing experienced care workers. They said they covered the topics of fire safety, safeguarding adults from abuse and moving and handling. One person told us that their induction included sitting on the hoist to experience what it was like for people who needed this type of assistance.

Each member of staff had an individual training record in place that recorded the training they had completed at previous work places and at Meadowfield Lodge. The registered manager told us that they considered mandatory training to include moving and handling, fire safety, health and safety, safeguarding vulnerable adults from abuse, infection control, food hygiene and first aid. The training records we saw evidenced that most staff had completed this training.

In addition to mandatory training, some staff had attended training on DoLS, MCA, dementia awareness, mental health, end of life care, stroke awareness and the risk of falls. Staff were booked on training during the forthcoming months, including moving and handling champion training, diabetes, safeguarding adults from abuse and medication. Staff told us that, during the last year, they had completed training on fire safety, MCA, diabetes and Parkinson's. This evidenced that staff were offered a variety of training courses to keep their practice up to date.

Good

Is the service effective?

Training records evidenced that all but one member of care staff had achieved or was working towards a National Vocational Qualification (NVQ) at Level 2, 3 or 4, and that the registered manager was undertaking this award at Level 5. In addition to this, one domestic assistant had achieved a NVQ award in housekeeping. This evidenced that staff were encouraged to undertake training programmes that would give them the skills to carry out their role.

People who lived at the home told us that staff seemed to have the skills they needed to carry out their role. This view was supported by a health care professional who we spoke with. The registered manager told us in the PIR document that they checked staff performance by observation, supervision and appraisal, including how they communicated with people who lived at the home, visitors and professionals. We saw evidence of staff supervision meetings within staff records; this meant that staff had an opportunity to talk about their own support and training needs with a manager. Records evidenced that the topics of infection control and using the correct moving and handling procedures had been discussed with all staff during their supervision meetings. Staff who we spoke with told us that they were well supported and that they attended supervision meetings with the registered manager.

Handover meetings took place to ensure all staff were aware of people's up to date care needs. People who lived at the home and visitors told us that communication between them and staff was good. One person said, "There is not one of them that talks down to you" and another told us, "They chat to me and I get involved with them." A relative told us, "Staff listen - you only need to say something and it is done."

One relative mentioned that the staff who did not have English as their first language were sometimes difficult to understand, although there were now less overseas staff working at the home. The registered manager told us that there were three staff who did not have English as their first language; they were always on duty with English speaking staff. One night care worker had been asked to work day shifts and their spoken English "Had improved 100%." This showed that the home had been proactive in ensuring people who did not have English as their first language were able to communicate effectively.

People who lived at the home told us that they had good access to GPs and other health care professionals. One person told us, "I tell the staff and they get a doctor" and another said, "They always consult the doctor if I am not well, and I see a chiropodist." Visitors told us that they were kept informed of any changes to their relative's health and well-being. One person told us, "They keep in touch – excellent."

Health care professionals told us that staff asked for advice appropriately and they listened to that advice and followed it. There was a record of any contact people had with health care professionals; this included the date, the reason for the contact and the outcome, plus a record of any advice given. We saw records of appointments and contacts with GP's, district nurses, dieticians and speech and language therapists (SALT). We noted that advice received from health care professionals had been incorporated into care plans. Details of hospital appointments and the outcome of tests / examinations were also retained with people's care records. In addition to this, people had personalised care plans in place that had been produced by the GP's surgery. These included details of the person's medical history and their current prescribed medication. This meant that staff had easy access to information about people's health care needs.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are unable to verbally communicate their needs to hospital staff. We saw that the patient passports developed by Meadowfield Lodge also included a record of the person's prescribed medication. This meant that hospital staff would have access to information about the person's individual care and support needs.

We observed the lunchtime experience and saw that the meal served looked appetising and hot. We saw that people were assisted appropriately to eat and drink, and that one person was provided with a clothes protector.

The cook told us they prepared porridge for people who wanted to have a hot breakfast and then lunch. They left a tray of sandwiches for the tea-time meal and care staff prepared meals such as soup or 'something on toast'. The cook told us they prepared home baking each day; they had made shortbread and fresh cream cake on the day of the inspection. They said they told people about the meal choices every morning and we saw people being offered a

Good

Is the service effective?

choice of dessert and drinks; one person had a glass of shandy. We also saw that people were offered drinks throughout the day. However, there was no menu on display to assist people with cognitive difficulties to choose a meal. The registered manager told us that the menu had been taken down due to the redecoration of the room and would be displayed again when the decorating had been completed. She said there was currently no-one living at the home who could not understand the choices explained by the cook, but they would consider using picture menus if this became the case.

People told us they liked the meals provided at the home and that staff were aware of their nutritional needs and their likes and dislikes. Comments included, "Very good. I can only eat certain foods and staff know", "They come around and there is usually a choice – I like fish and chips" and "We get a choice of two options for lunch. Staff know I can't chew at the moment and they bring me appropriate food."

When nutrition had been identified as an area of concern, we saw that appropriate referrals had been made to health care professionals, and that their advice had been incorporated into care plans. Staff told us that care plans recorded when people required a special diet, such as a fortified meal or a soft diet. They said that this information was also recorded in the kitchen. We saw that charts were used to monitor food intake, and fluid intake and output. These charts were detailed and had been completed consistently. People were also weighed as part of nutritional screening. This ensured people's nutritional intake could be monitored to promote optimum health.

We asked people if the signage that was in place to help them find their way around the home was sufficient. All of the people who we spoke with told us that they could locate bathrooms, toilets or their bedroom. Two people said they moved around the home in a wheelchair assisted by staff, so this was not relevant to them. The registered manager acknowledged that more attention would need to be paid to signage, colours and ways of helping people to identify their bedroom if people's cognitive abilities deteriorated.

Good

Is the service caring?

Our findings

People who lived at the home told us that staff cared about them. Comments included, "Yes, I just know they do", "I think they do a really good job" and "Some more than others, nevertheless they are there." Relatives / visitors who we spoke with told us they felt staff really cared about people who lived at the home. One relative said, "Yes, they just generally care, very kind and do whatever they need." Staff told us that they felt all staff who worked at the home genuinely cared about the people who they were supporting. We also asked people if they thought the care centred around them and people responded positively. One person told us, "They are very good to me" and another said, "They look after us all."

Staff told us that they read people's care plans and that these included information that helped them to get to know the person, such as their hobbies and interests, their family relationships and their likes and dislikes. Staff told us that they had time to spend with people and they got to know about people's individual needs by reading the care plan and spending one to one time with people. We observed positive interactions between people who lived at the home and staff throughout the day.

A health care professional told us that when they needed to discuss people who lived at the home with staff, they were always knowledgeable about their needs. They told us that when staff discussed concerns with them about people's general health, they had usually made some kind of assessment about what they thought might be wrong with them. When the person was assessed by a health care professional, staff at the home were "Usually not too far off." They added, "I cannot fault the care."

When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.

There were systems in place to ensure information was shared with people, including meetings with people who lived at the home and relatives. We asked people if they were kept informed about what was happening in the home. One person said, "(The manager) would come around and tell us – at the moment they are redecorating."

On the day of the inspection we saw that people were encouraged to make choices and to be as independent as possible. Relatives told us that people were encouraged to do as much for themselves as they could, and this was supported by staff who we spoke with. One member of staff said, "We try to get them to do as much as they can for themselves." A person who lived at the home said, "I am left to my own devices, which I like."

The registered manager told us in the PIR document that people were encouraged to bring their own belongings into the home to help them 'feel at home', and they could choose the colour of the décor in their bedroom.

On the day of the inspection we saw that people who lived at the home were well presented, appropriately dressed and wearing suitable footwear. They were wearing a style of clothing that they had obviously chosen. The hairdresser was present and several people had their hair done; we were told that the hairdresser attended the home each week.

People told us that staff respected their privacy and dignity and said that they always knocked on the door before entering; one person said, "Everybody knocks on the door" and another told us, "It is always respected." Staff were able to describe to us how they protected a person's privacy, such as closing doors and knocking on doors before entering the room. One member of staff told us, "I am the dignity champion. I check curtains and doors are closed."

In February 2015 the registered manager had carried out an assessment on each member of staff in respect of dignity. Staff completed a self-assessment as part of this process, and there was a group discussion about how staff could evidence their commitment to treat people with dignity and respect. It was agreed that the assessment would be repeated in a few months' time to check that people were still working in a respectful way, or if their practice had improved (if needed).

The registered manager acknowledged that they needed a larger toilet so that there was room for staff to assist people who needed to use the hoist so that their dignity could be maintained; there were occasions when the toilet door could not be closed properly due to lack of space. The registered manager told us that they had reported this shortfall to the registered provider.

There were three wet (shower) rooms at the home; one on each floor. However, there was no bathroom. The

Good

Is the service caring?

registered manager told us that people who currently lived at the home were happy to get a shower and that no-one had raised this as a concern. She said they would arrange for people to use the bath at one of the organisations other homes that was close by if they asked to have a bath. It was acknowledged that this was not an ideal arrangement and that people should have the choice of a bath or shower.

All of the people we spoke with including people who lived at the home, relatives / visitors, staff and health care professionals told us that they were confident that any issues that were of a confidential nature would remain confidential.

Good

Is the service responsive?

Our findings

There was no activities coordinator employed at the home but we saw that care staff had sufficient time to ensure activities were made available to people. There was a weekly activity list on display and people living at the home told us they were aware of this. One person told us, "Whatever is going on I will do" and another said, "There is a man comes in and sings and the manager takes me out when she can." We saw that one person went out shopping with a member of staff on the day of the inspection.

Staff told us that people had their hair and nails done and that other activities included entertainers, movie afternoons, a motivation class, games and a monthly church service. We saw some of these activities taking place on the day of the inspection.

The registered manager told us in the PIR document that a mini bus had been sourced so that people "Can access the outside world." One person told us, "There is a bus that comes and takes us out roughly once a month." This meant that people were able to access the local community.

Relatives told us that they were welcome to visit the home at any time and they were always offered a drink. Staff told us that relatives were also invited to stay for a meal to promote good relationships between people who lived at the home and their relatives / friends. Some of the people who lived at the home had a mobile telephone and other people were able to use the home's telephone so that they could keep in touch with family and friends.

The registered manager told us in the PIR document that the person concerned and their family and friends were involved in developing care plans so that they were a detailed record of the person's previous lifestyle, likes and dislikes, family relationships and care and support needs.

People who we spoke with were not familiar with the term 'care plan'. However, we saw that each person had a care needs assessment, a care plan and appropriate risk assessments in place. They covered topics such as communication, personal hygiene, mobility, tissue viability, diet and nutrition, mental capacity, pain, medication and night care. We saw that care plans and risk assessments were reviewed in-house each month. In addition to this, we saw that more formal reviews of care plans were carried out by the local authority. When formal reviews were held, people who lived at the home were invited to attend these meetings to discuss their care and support needs. Care plans had been updated when needed and this meant that staff had up to date information to follow about the people who they were supporting.

The registered manager told us in the PIR document that they had not received any formal complaints during the previous twelve months. They said there was a complaints procedure in place and they would deal with any complaints immediately. We asked the manager what action they would take if they received a complaint and they were able to explain the process they would follow. They also said that any complaints received would be audited to identify any need for improvement in the service.

People felt that their concerns were listened to and that appropriate action was taken; they said they would not hesitate to speak to the registered manager if they had a concern or complaint. One person told us, "I would tell the carers and I would also tell the manager but I have no complaints" and another person said, "I would tell (the manager) – we get on very well together. I once complained my food was cold and they now warm the plate and it is better." The registered manager told us that there was a copy of the home's complaints procedure in every bedroom.

All of the relatives / visitors we spoke with told us that they would not hesitate to contact the registered manager and they were confident any issues would be dealt with professionally and promptly. One visitor said, "She seems like a good leader – she listens. For example, we said (person's name) room needed to be decorated and it was done immediately." Staff told us that the registered manager would listen to people's complaints. One member of staff said, "Yes, she's quite good (the manager) – 100% for the residents."

Good

Is the service well-led?

Our findings

The local authority quality monitoring team carried out a routine visit to the home in November 2014. They recommended that discussions with health and social care professionals were captured in records and we saw that this was now taking place. The registered manager was also advised to keep appropriate records of supervision and we saw these records on the day of the inspection. This showed that the registered manager had listened to advice that she had been given to improve record keeping at the home and understood her role. On the day of the inspection we did not identify any concerns about record keeping.

A health care professional told us that there had been a recent query at the home about staff's moving and handling skills. As a result, all staff had completed refresher training on this topic. Again, this evidenced that the registered manager was proactive in responding to any concerns raised.

The registered manager told us in the PIR document that they held 'resident and family' meetings. They said that in recent meetings people had been consulted about the redecoration of the home, outings and menus. We saw minutes of a meeting that had been held in June 2015. These recorded that people had been asked what colour they would like the walls in the lounge to be painted. People expressed a preference for green, and we saw that the walls had been painted in this colour. The minutes recorded that everyone present had been asked if they had any concerns and everyone said they were happy. The previous meeting had been in May 2015 and the minutes recorded that the registered manager had apologised to everyone for the disruption caused by the redecoration of the home. Outings were also discussed and again, everyone said they were happy at the home.

We saw minutes of staff meetings; the most recent meeting had been in April 2015. The topics of infection control, working 'on the floor', communication and food / drink were discussed. Staff told us that they were able to raise issues and have 'open' discussion at these meetings, and they felt they were listened to. There had also been a staff survey in December 2014 which was another opportunity for staff to express their views.

The registered manager told us that a suggestion box was being made so that it could be displayed in the home to invite suggestions from people who lived at the home, staff and visitors.

Satisfaction surveys were distributed to people each year. A survey was given to people who lived at the home in February or March 2015. Eight surveys were returned and collated by the registered manager. Overall, the comments were positive, including, "Care staff are very good. Catering is good and plenty of choice" and "Enjoying the trips out and in-house activities." There had been a separate survey about food in May 2015. Responses were mainly positive and people were asked to list their favourite foods so they could be included on the menu.

A relative survey was conducted in December 2014 and five surveys were returned and collated. Again, responses were positive. Respondents reported that their relatives were safe, that the food was very good, that they had never had any concerns and that there was a good atmosphere at the home. We also saw records of one to one meetings that had been held with some relatives in February 2015.

People who lived at the home who we spoke with could not remember completing a survey. However, they spoke very highly of the manager. Comments included, "(The manager) is wonderful", "Anytime anything that is important to me, I can approach (the manager)" and "Anytime – you couldn't have better – can't praise her enough." All of the relatives we spoke with told us that they would not hesitate to contact the registered manager and they were confident any issues would be dealt with professionally and promptly.

We asked people about the culture of the home. Visitors told us that there was a positive atmosphere. One visitor said, "I have no grumbles. Mum is very happy here – there is a calm and pleasant atmosphere" and another said, "(The manager) runs a happy ship." Staff told us there was a family atmosphere at the home and that the registered manager was a good leader. One member of staff said, "I think it is well run. (The manager) is always there and you can always go to her" and another said, "(The manager) is great. She is the best one we have had."

The registered manager told us in the PIR document that staff were given opportunities to progress within the company, and that they planned to introduce 'Employee of the month' as an incentive to staff. They told us that they

Good

Is the service well-led?

already had a moving and handling champion at the home but they planned to introduce more champions. Champions are members of staff who take the lead on a certain topic; they promote their topic by receiving relevant information and ensuring that it is shared with the rest of the staff group.

We saw examples of monthly audits that were recorded in a quality matrix, although we noted that these records only went up to March 2015. These monthly audits covered checks on window opening restrictors, fire alarms and pressure care equipment. The registered manager explained that these checks were now carried out by the housekeeper or maintenance person, and that separate records were kept. We saw more detailed audits on infection control, care plans, accidents and incidents and medication. These audits identified areas that required improvement and there was usually a record of when the work had been carried out.

We asked staff if there had been any learning from the analysis of accidents, incidents or concerns. One member of staff was able to describe a situation where a person's safety was improved following discussions about their posture and use of a cushion. Staff also told us that people who lived at the home were asked about the menu and changes were made after listening to their suggestions.