London Residential Healthcare Limited

Acacia Care Centre

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 took place on 14 and 15 April 2016. Day one of the inspection was unannounced.

Acacia Care Centre is a purpose built care home providing nursing care for up to 62 people who may have poor health, dementia, or other needs including mental health and learning disabilities. The service has a designated dementia unit. At the time of the inspection 59 people were using the service.

The service was last inspected in March 2015, it met all the regulations we inspected it against.

The service had a registered manager in post; they were available at the time of the inspection. '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.'

Policies and procedures including appropriate risk management processes were in place to make people were protected from the risk of harm. Staff were trained and understood safeguarding procedures. Appropriate robust recruitment checks were undertaken to make sure only suitable staff were employed.

Staffing levels were suitable with an appropriate skill mix deployed to meet the needs of people who used the service. Staff employed were appropriately supervised and supported, staff morale was good. There was an on-going training and development programme to enable staff continue with their professional development. It was acknowledged that additional training was needed in dementia care.

Acacia Care Centre was a well maintained premise, furnished, clean and hygienic, and provided a safe environment for people to live in and staff to work in.

Staff responded promptly to individuals seeking advice and consulting with relevant health professionals if there were any concerns. The number of general practitioners involved with people at the home has been reduced to five, this has helped people experience improved outcomes as they regularly consult with the same GP.

People consented to the care and support they received. Staff supported people in line with the principles of the Mental Capacity Act (MCA) 2005, holding best interest meetings when required.

People's preferences and choices were known and respected; they received care and support as planned. Staff knew the people they cared for well and could respond to their individual care needs and preferences. Staff were kind and patient, they were mindful to take into account people's privacy and dignity and consider their individuality.

The registered manager and staff were clear about their roles and responsibilities; staff were motivated and worked well as a team. They were committed to providing a good standard of care and support to people who lived at the home. The home had a complaints system which addressed any complaints within the agreed timescale. The service had developed a quality assurance system; driven by the views of people, and combined with quality audits to make improvements.

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. Staff were trained in safeguarding and knowledgeable about protocols to follow that protected people from abuse. Risks to people were identified and appropriate management plans were put in place which staff followed. These arrangements were consistently applied and helped to reduce the likelihood of people coming to harm.
There were enough suitably skilled staff deployed to safely meet people's needs. Recruitment procedures were robust, only suitably vetted staff were employed.
Medicines procedures were safely managed.

Is the service effective?

Good

The service was effective. People received care from staff who were provided with relevant training. Teamwork was good and staff found they were effectively supported by managers.

Staff communicated and worked well with other health professionals. They used their guidance and followed recommendations to ensure people's healthcare needs were met. Staff asked people for their consent before delivering any care. Staff understood the provisions of the Mental Capacity Act and Deprivation of Liberty Safeguards, and supported people in line with the principles of the Mental Capacity Act (MCA) 2005.

Is the service caring?

Good

The service was caring. People were cared for by staff who were familiar and who built positive caring relationships with them.

Staff were kind and considerate, they displayed warmth and empathy to people. People were involved in making decisions about their care and were consulted on advanced care planning decisions. The service provided compassionate care for people, and provided for their needs in the final days of their life.

Is the service responsive?

Good

The service was responsive. People were consulted on their choices and preferences, and involved in identifying their needs and developing their care plans.

The service identified individual needs, they made suitable arrangements to ensure people received good quality care and support which met their individual needs.

People had no complaints but felt confident that if they had any concerns or complaints these would be addressed by management satisfactorily. Complaints were responded to appropriately and people felt their views of the service mattered.

Is the service well-led?

Good

The service was well-led. The registered manager had in place clear lines of responsibility and accountability.

The registered manager had a visible presence throughout the service, people and staff felt the registered manager was supportive and approachable. The management team had oversight of and acted in the best interest of people to maintain the quality of the service provided. The service sought feedback from people receiving support, relatives and staff.

Acacia Care Centre

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 14 and 15 April 2016, day one was unannounced. The inspection team included two adult social care inspectors, a specialist advisor (a social worker with dementia care background), 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 took part in this inspection had experience of dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to this inspection we reviewed all the information we held about the service, including our data about safeguarding and statutory notifications. Statutory notifications are submitted to the Care Quality Commission and tell us about important events which the provider is required to send us.

Not everyone was able to verbally share with us their experiences of life at the home. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how staff interacted with people who lived at the home. We observed how people were supported during meal times and during individual tasks and activities.

We spoke with a range of people about this service. They included the clinical director of the organisation, the registered manager, clinical nurse manager, ten staff which included the activities coordinator, the chef, the maintenance person, twenty people who lived at the home and eight relatives. We checked documents in relation to ten people who lived at Acacia Care Centre and six staff files. We reviewed records about staff training and support as well as future training plans, and records related to the management and safety of

the home.

Good

Is the service safe?

Our findings

People told of feeling safe. One person told us, "I can call on staff when I need help, they respond to my calls quickly." We saw that call bells were placed within easy reach of people, this ensured people who were bed or chair bound could easily summon assistance. Observations made during the inspection visit showed people were comfortable in the company of staff supporting them. One relative told us "I have confidence in the staff because they ensure my spouse is safe and protect them from harm as much as possible." Another person told of the reassurance from staff since their family member moved to the home, they said, "Myself and my family have complete confidence in staff, they have earned our trust as they can be relied on to provide all the care my relative needs."

The majority of people said they enjoyed living in a comfortable home that was clean and safe. We observed the premises to be clean, tidy and well-maintained. Relatives and visitors complimented the home on the standard of hygiene maintained. Staff followed infection control procedures and made appropriate use of personal protective equipment, for example, wearing gloves and aprons when necessary.

Care and support was planned and delivered in a way that helped ensure people's safety and welfare. Prior to admission needs assessments were carried out by a senior member of staff. The assessments identified risks associated with their care needs. The risk assessments determined if the service was appropriate and if a safe service could be provided. Risks such as moving around the home safely, use of bed rails, skin integrity, falls, pressure care and malnutrition were assessed and appropriate management plans implemented to address those risks. A healthcare professional involved with people in the home told us staff were particularly good at following directions and recommendations, the nursing staff came in for particular praise.

Staff were aware of risk management plans and utilised guidance in care plans to deliver care and support appropriately. For example, staff were trained and used hoists and wheelchairs in an appropriate way to transfer people, for those at risk pressure relieving equipment was used to promote tissue viability. Wound care was well managed. Care plans detailed the assistance required by the person to get out of chair; standing; walking; toileting; general transfers. Guidance for staff about equipment needed and how many staff required. People with swallowing issues were managed safely, and referred to speech and language specialists (SALT). We observed that staff followed professional's recommendations to help protect people against the risk of choking, for example people were nil by mouth and receiving enteral feeding (tube feeding) were positioned correctly to avoid aspiration of fluids.

There was a fire risk assessment in place with firefighting equipment serviced and maintained, such as weekly testing of smoke alarms. Although the provider had systems in place to minimise risk and protect people in the event of an emergency a recent visit was made by the fire department. They made recommendations for the service provider to implement changes to fire risk assessment and evacuation plans and these actions were due for completion by July 28th 2016. The registered manager told us of the progress with plans to address these deficits.

The service had procedures in place to minimise the potential risk of abuse or unsafe care. Records confirmed the registered manager and staff had received safeguarding of vulnerable adults training. Staff demonstrated a good understanding of how to safeguard people from abuse. Staff told us they would raise an alert if they had any concerns about inappropriate practice or conduct. A local authority officer and a social worker reported to us staff had made relevant reports and cooperated with any investigations; there were no concerns about safeguarding procedures in the home.

A recruitment and induction process was in place that helped ensure only suitable staff were appointed to support people. Staff followed safe recruitment practices. We looked at six staff files and noted they contained relevant information. This included a Disclosure and Barring Service (DBS) check and appropriate references. The DBS check helped the provider to make safe recruitment decisions and prevent the employment of unsuitable staff from working with vulnerable people.

We looked at staff rotas and, observed care practices, and spoke with people. The deployment of staff throughout the day was well organised. Staff worked in specific areas. Staffing levels were suitable on the day with an appropriate skill mix to meet the needs of people who lived at the home. The daily allocation sheet clearly showed staff their specific personal responsibilities on the shift, people they were responsible for; staff breaks staggered times. This showed the service promoted consistency; these systems allowed people to get to know staff and for staff to get to know people's support needs. For example one person told us of becoming upset if certain daily and night routines were not followed. They found that only regular staff knew and were familiar with these, they said the manager usually assigned the same staff which showed the efforts made to deploy staff correctly. The majority of people told us there was generally enough staff on duty, but some relatives told us they had observed some staff absenteeism's at weekends due to illness. One visiting relative told us, "I come here regularly. I sometimes think there could be more staff but generally it's pretty good." Although the dementia unit had one nurse and four staff on duty to care for 18 people there were times outside of mealtimes when additional numbers of staff could have delivered more individualised care to people. The registered manager acknowledged that there have been occasions when carers have not been able to attend at weekends but they relied on regular staff to cover these as much as possible. On day two of the inspection a member of staff reported as being unavailable to attend their shift; their role was undertaken by another regular member of staff on their day off.

We examined medicine procedures. Medicines required and prescribed for people were in stock and stored securely. Qualified nurses who were trained administered all medicines. Staff told us there were no people self-administering medicines. We observed staff administering medicines, this was done as the instructions directed. Medicine records (MAR) were accurately maintained, regular monthly medicine audits identified any gaps in medicine management and appropriate actions were taken to address any shortfall. A pharmacy inspection took place in recent months to examine medicine procedures in the home and identify any shortfalls. The registered manager told us the service experienced issues with requesting medicine, and as a result another dispensing pharmacist became involved. Staff told us the new pharmacy arrangement was much more effective for the home. A number of people were prescribed essential medicines, but lacked capacity to agree to medicines, and were receiving medicines covertly. The service followed protocols with the assessment process for administering covert medicines. The GP, pharmacist and staff were involved in making the decision in the person's best interests, and the assessment and decision making process was reflected in records. Staff were familiar with protocols for administering covert medicines.

Good

Is the service effective?

Our findings

People using the service were positive about the care they received at Acacia Care Centre. One person said, "I like living here, my room is lovely and staff are great and look after all my needs." Another person said "Staff are good and know what they are doing; when I was unwell they knew this and called the doctor who prescribed medicine, this has made me well again."

Staff developed the skills and knowledge required to care for people effectively, the service had a training and development programme in place for staff. Staff told of receiving an initial induction following appointment, after this they had the training they needed to care for people. Staff said they had completed their mandatory training. One nurse said she was supported with continuing professional development and received additional training, they recently completed chronic illness course paid for by the provider. They said, "We get a lot of support from the manager." Another qualified nurse said, "I attend all the training for my role, there is professional development for qualified nursing staff, such as phlebotomy and use of syringe drivers for pain management." Another staff member said, "I have learned so much since I came to work here, the majority of carers have National Vocational Qualifications. There is a good training programme for staff, and managers monitor that we attend training." Staff felt inspired and some went ahead outside of work achieving their goals in National Vocational Qualifications. One carer had completed all mandatory training, they were studying in own time, and just finished NVQ L5 in health and social care, they wanted to achieve their aim of becoming a social worker.

Records maintained of training attended showed that staff attendance was monitored. Staff had attended training across a number of areas including safeguarding adults, first aid and the Mental Capacity Act. There were opportunities for staff to participate in specialist training and staff engaged in training specifically linked to the needs of people using the service, for example, end of life care, and management of wound care. A large number of staff had completed a National Vocational Qualification (NVQ) award in care, which helped with their learning and good practice. A health professional told us of the positive impact people experienced due to staff learning, they found staff were more knowledgeable and could understand and implement recommended changes. It was acknowledged this had improved practice as a result. Although staff had completed basic training in dementia care their practice identified there was a further training need in terms of increasing staff effectiveness and improving outcomes for people. The registered manager acknowledged the need for further staff development in this area and was planning to source further training.

Staff spoke of feeling supported effectively in their job role. Records confirmed formal supervisions were provided for staff every quarter. These covered development needs; training; team work; attitude, and practice issues. Staff said they could discuss their work and identify any training needs in one to one sessions of supervision. Regular team meetings were held where topics such as safeguarding, mental capacity and good practice were discussed. One staff member said, "I feel well supported here and team work is excellent" and this view was confirmed another staff member who has worked at the home since it first opened.

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. We saw consent was obtained as required from each person around the support provided by staff. Records showed where people lacked mental capacity and were unable to make decisions, 'best interests' meetings were held. Staff had completed Mental Capacity Act training; this supported them to understand issues around capacity and recognise changes in people's capacity and assess individual's mental capacity. People told us staff asked for consent before providing care and support. 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. 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. A number of people were subject to DoLS and deprived of their liberty to receive care, this was legally authorised by local authority staff. The service was working within the principles of the MCA. The registered manager and senior staff demonstrated a good understanding of the principles of MCA and DoLS. The registered manager had made a number of other referrals to the local authority for authorisation of DoLS, however these were awaiting a response from social services staff.

Menu planning was in place and preferences discussed and taken into account during resident's meetings. People said their views were taken into account; they were mostly pleased with the quality of meals. On the day of inspection we observed breakfast and lunchtime. A choice of food was offered. The food was appetising and plentiful and observed staff explain to people what was on their plate. People came in and left in their own time and chose where they sat. Staff were aware of individual likes and dislikes of people who lived at the home. For example they knew one person had a poor appetite, with a lot of encouragement from staff the person ate a banana for breakfast. One person told us, "I get nice food and I can have as much as I want." Another person stated, "The food is quite nice, they give you something else if you do not like what is on the day's menu." Drinks were offered throughout the day. Teas, coffees and juice drinks were available with meals and in between times. People in bed due to medical needs had drinks placed close to hand. We observed staff encouraging people to drink fluids during the day and serving alternate drinks to accommodate individual taste. One staff member told us, "We make sure people have plenty of fluids and good food to promote good health." Records showed and staff confirmed specialists such as dieticians were consulted as necessary when people displayed signs of nutritional risks. Food and fluid charts were maintained consistently for those identified as at risk of malnutrition or dehydration. Nutrition and people's weight was monitored. Daily notes showed where some people had made necessary progress and improved and were no longer at risk. This showed people were protected against the risks of dehydration and malnutrition. Care records recorded special dietary and cultural needs; these were provided to the chef. Staff knew who about special diets, who required fortified drinks and the preferences of people who lived at the home.

People's healthcare needs were supported appropriately; these were carefully monitored and discussed with the person as part of the care planning process. Care records included daily logs of progress, as well as reports by the Multidisciplinary Team (MDT), these confirmed visits by general practitioners and other healthcare professionals. During our inspection three health care professionals visited the home to manage on-going treatments. One person was receiving therapy from two physiotherapists who visited. Other health professionals that visited throughout the year included a dentist, the chiropodist and optician. Records we saw were informative and documented the reason for the GP visit and the outcome. The service has worked with the local CCG to reduce the number of GP practices involved with people in the home, this has proved to be beneficial and one GP attends the home every week to hold a surgery. One staff member told us, "As

soon as someone becomes unwell concerns are taken up quickly and a doctor is called. A second staff member said, "We know people and recognise when things are not right. The doctor responds to our requests, comes to visit and this is recorded in daily records as well. This demonstrated there were good communication protocols in place with health professionals so that people received continuity of care and healthcare needs were promoted.

The premises were purpose built and the layout was good. There was a dementia unit which was designed specifically with this need in mind, other areas of the premises were not dementia friendly and lacked signage. We saw that each person had their own room, with an en-suite bathroom. There were also assisted bathrooms and toilets on each floor. The service had a number of communal areas throughout the home including a library, coffee lounge and a bar. This gave people a choice of where they wished to spend time or take their visitors. There was also a large accessible garden to the rear

Good

Is the service caring?

Our findings

People and relatives gave positive reports about the calibre of staff and the special caring attributes they possessed. One person wrote to us following the inspection to convey their views, they said, "During the many visits I have made to Acacia over the past two and a half years I have always been amazed by the efficiency, compassion and forethought shown by the staff." One person communicated with us during the inspection by signing and gesturing, they expressed they were very happy in the home; they smiled and acknowledged the good relationship they had with staff. They were at ease with staff who understood their communication methods. The person's relatives told us, "I cannot praise staff enough, they are thoughtful and have integrity, we can go away on holidays knowing he is looked after by kind caring staff."

We observed positive interactions and communication, good practice between staff and people who lived at the home. Relationships between people and staff were warm and friendly, compassion and kindness were shown by staff, who were seen to listen carefully to what people said or expressed via body language. Some staff had more specialist skills and showed their experience of caring for people with dementia. This was particularly obvious at mealtimes. We observed some staff kept good eye contact, engaged well and encouraged people they supported with eating their meals. Staff explained the tasks they proposed to do such as transferring the person in the wheelchair. We observed an example of practice that was not so good, one carer assisted two people simultaneously at mealtimes. On one unit a member of staff on duty was a dementia champion, they were aware of the importance of staff having further training and an understanding of dementia care. On the dementia unit two relatives were present in the dining area and both were involved in supporting their spouses. They came every day to support their spouses with meals.

Staff were knowledgeable on people's past and present changes and how this had contributed to changes in their personality and activities they liked to engage in. We observed staff acknowledged and responded appropriately to individuals who needed assistance and who liked to walk about. There were two lounges and additional seating areas that offered people solace and space. People were able to bring personal belongings into their rooms, such as pictures and ornaments to make their new environment more personalised. We observed that bedrooms contained people's personal possessions; people were surrounded by mementos from their homes such as ornaments and family pictures. One person was becoming anxious about their spouse not being present, the carer responded sensitively and reassured the person they were safe and secure in their care until the relative came. This worked and the person engaged with the carer in talking about other important events in their life. Another relative visiting stated, "I think the staff here are wonderful. That was the reason we chose the place originally and we have been pleased."

Staff supported people in a way that respected their privacy and dignity. We saw that staff closed doors when supporting people with personal care tasks, promoted their modesty and self-esteem by ensuring they were dressed appropriately, people had their hair groomed and nails manicured. We also saw that staff communicated with people and informed them about what they were doing when carrying out tasks with them. For example, we saw staff transferring a person from a wheelchair to a chair. They interacted with the person and informed them of what they were doing and provided reassurance to them to reduce any anxiety. Staff spoke in tones that people found comforting, they showed in practice they understood the

importance of treating people with respect.

The service provided end of life care to people who were at that stage of their life. People's care records recorded care and support people wished for and needed as they approached the end of life. This included records of discussions with people and relatives, recording their decisions about spending their final days in the home or going to hospital when they become unwell. Information also held were original records of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) agreed and signed by the GP. These records showed that people and their relatives were involved in planning their care in detail. Staff understood people's care and respected the choices they had made in relation to their end of life care. Staff told us that the majority of people were able to be cared for in accordance with their wishes unless an emergency arose that resulted in hospital admission for treatment. The service was reaccredited to the Gold Standards Framework Centre in End of Life Care in April 2016. The award confirmed the service had demonstrated their ability to deliver quality care to people in the final stages of life.

Good

Is the service responsive?

Our findings

People able to share with us told us the support and care they received met their needs. People's care and support was planned and delivered in a way that met their individual needs. Staff told us they visited people to carry out pre-admission assessment of needs. Staff used the information gathered during this process to determine if the service could meet the person's needs on admission. Care records showed that the assessment gathered important information about people's background, histories, preferences, health, medical and social needs. People and relatives were provided with a range of information to help them make the decision on which service to choose. Relatives told us that they were able to visit the home for a trial visit before they moved in.

Staff told us that they observed people closely when they were first admitted so they could monitor and understand well their support needs patterns and behaviours. This helped them tailor their care plan to their individual needs. People admitted were referred and registered with one of the local GP practices. Staff told us people were included on the doctor's list and seen in the first week following admission. However if an emergency call out was needed staff requested a visit by the doctor. Care records showed that people were checked at regular intervals at night, and people who required position changes were turned at recommended times. Staff developed care plans involving people and their relatives. Visiting professionals, relatives spoke positively about the service. One person wrote the following, "I was concerned about a person placed, they had dementia and were in an extremely anxious state when they arrived, I was very concerned about their ability to adjust to his new surroundings. Staff enabled them to 'settle in' very well and this same high quality care has continued all the way through to the present."

Care plans covered people's diverse needs and how they wanted to be supported by staff. For example, a care plan detailed the support a person cared for in bed required to ensure their health and well-being were maintained. It included regularly checks from staff to ensure they were not isolated, two hourly re-positioning to reduce the risk of pressure sores and how to correctly position the person when using PEG feeding. We observed staff kept a close eye on these people frequently dropping to see them and have chat. Staff were well informed on taking appropriate action to respond to individual needs. Daily records confirmed that staff were following guidance, observations were also made by the clinical nurse to ensure good practice was promoted. One person told us, "I have health problems, staff keep an eye on them and make sure I am okay, I need to attend hospital for treatment three times a week." Another person said, "Staff look after me well and recognise when things are not going well, and call the doctor to review my treatment." A health professional commented positively on the responsiveness of staff, and said, "Staff are knowledgeable and familiar with the needs of people in the home, they identify and respond appropriately when things are concerning, they promptly seek assistance from us." A visitor told of the prompt and appropriate actions by staff when their relative was unwell gave them confidence in the service. We observed that staff handovers were comprehensive and essential information about changes to individual needs were shared with the staff team, we observed staff followed these changes when carrying out their duties. But we noted staff did not always pay attention to detail in daily notes, we found examples of staff recording some minor but inaccurate details which we brought to the attention of the management team.

People told us they received the care and support they required. One person told us, "Some like a daily shower and staff assist them with this." Others told us they had a shower twice a week and this suited their needs. Care plans were reviewed monthly or more frequently if required to ensure they were up to date and reflected people's needs. We saw numerous examples of care plans being updated when people's needs changed in relation dietary requirements, mobility, and health needs. Appropriate referrals took place to relevant health professionals. Recommendations were made by professionals and implemented in care planning arrangements. For example, an occupational therapist was involved to provide equipment people required to maintain their independence as much as possible such as walking frames.

There were a range of planned activities at the home which people could participate if they wished. Two activity coordinators were employed, one of them was a carer until recently and had a good knowledge of the people in the home. People we spoke with told us that they were involved in activities such as quizzes. People talked about other activities they had participated in such as tea parties and day trips. One person told us they and friends in the home had gone to a large shopping centre in Croydon the day before we visited, they had enjoyed this occasion. They told us staff were planning day trips to the coast for people during the summer. During our inspection, we observed people were sitting in the garden and enjoying the sunshine and talking and laughing with staff. It was noted that staff encouraged people to take part in activities such as singing and playing a variety of games. Other people were doing activities on their own such as reading, or watching television in their bedrooms, Staff took an interest in what people were doing and commented on their activities. In the dementia unit there were two lounges for people to choose from, one area was quiet and provided a calm environment for people when they become anxious or distressed. On another floor there was a sensory room where people were supported to engage in sensory activities. Some staff did not consider the environment and how it impacted on people's sense of wellbeing and comfort. We observed that televisions and music players were playing in one unit, and none of the people were enjoying it or taking any interest in these. Eventually a senior staff member recognised this and switched them off. The registered manager told of plans to develop more activities for people to enhance their lives, one of these they plan to introduce is an activity known as Namaste, this is a sensory care programme that provides particular benefits for people with dementia.

People and their relatives were asked for their feedback on the service at regular meetings. The minutes and people reported that at recent residents and relative's meetings people were asked for their views about the food and any issues related to the service. We saw that the registered manager had followed up on feedback from a relative about comments by a staff member.

People's complaints were fully investigated and resolved, where possible, to their satisfaction. There was a record of complaints that had been made, three were recorded for the past 12 months. All of them had been addressed by the service appropriately. People told us they felt reassured by the complaint's process. In the entrance hall there was a comments book for people to write in. There were also regular meetings held for people's relatives so that they were aware of what was happening in the home.

Good

Is the service well-led?

Our findings

The registered manager understood their responsibilities and was proactive in introducing changes within the workplace. The provider has made improvements and developed a more effective system to regularly assess and monitor the quality of service that people receive. There was clear leadership and management at the service, the registered manager was in post for more than two years and was well respected by staff and people in the home. The management has promoted a consistent approach in the home. She was assisted in her role by the clinical nurse manager. External health professionals spoke positively of the management team and their good working relationship and effective communication.

Staff were clear on their roles and responsibilities, and felt able to escalate concerns to the manager as and when necessary. People told us they knew and had confidence in the manager of the service. They felt able to speak with her and felt comfortable approaching her if they wanted to discuss any concerns of worries they had. The management style promoted open communication. Staff demonstrated they were aware of the whistle blowing policy. Staff told us that staff at all levels were encouraged and supported to openly communicate their opinions on the service. Team meetings were used as a learning opportunity to discuss issues such as safeguarding and mental capacity. Open communication was seen to be promoted through staff meetings, and staff were encouraged to put forward points for the agenda.

Managers received relevant training and development. They kept up to date with CQC regulation changes and attended seminars for this, they also attended local authorities' forums and presentations to ensure they kept up to date with legislation and good working practices. They monitored staff training provision to ensure it was current and the staff team was given the opportunity to develop the skills and knowledge needed in their role. Staff morale was good and there was good team work, staff were given opportunity to progress in the role and encouraged to follow their goals. When we discussed with the registered manager staff development they commented, "It is good to see people develop and gain more skills and have ambition. We encourage personal development." This demonstrated the registered manager valued and motivated staff.

The provider had systems for monitoring the service, identifying and addressing any shortfalls, and for driving improvements. This helped ensure it met the needs of the people who live there. Quality assurance processes included monthly reviews of care needs. Accidents and incidents were recorded, and notifications were made to relevant bodies in accordance with legislation.

Quality checks were completed and included looking at management and administration, staffing, mental capacity, nutrition, falls and medication. The registered manager and clinical manager audited care documents; people's care plans were up to date and reflected people's current needs. However we noted that risk assessments and daily care records were not included in the auditing process, and some anomalies were found in these records. We saw maintenance and safety certificate checks were made, and fire alarm drills had taken place however these were not audited as part of the monthly provider visit checks and there were some inconsistencies in records and tasks undertaken, we shared this with the person in charge. The registered manager was together working with the provider in addressing some shortfalls in the home's fire

risk assessment and processes, and showed us the progress already made.