Mrs Lila Chaudhary

Shamrock House

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 23 March 2016 and was unannounced. We previously visited the service on 10 April 2014 and we found that the registered provider did not meet all of the regulations we assessed. We carried out a follow up inspection on 25 September 2014 and found that the registered provider had met the regulations.

The home is registered to provide accommodation for up to 17 people whose main need is in relation to their mental health. On the day of the inspection the home was fully occupied. The home is situated in Goole, in the East Riding of Yorkshire; it is a short walk to town centre amenities and the bus and rail stations. There are two communal areas and bedrooms are located on all three floors of the premises. There is no passenger lift or stair lift so people who live at the home have to be physically able to manage the stairs.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people were working at the home.

People told us that they felt safe whilst they were living at Shamrock House. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

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. Staff had received training on the administration of medication and people had no concerns about how they received their medicines.

People told us that staff were caring and that their privacy and dignity was respected. They said that they received the support they required from staff and that their care plans were reviewed and updated as needed. People's nutritional needs had been assessed and people told us they were very happy with the food provided.

There had been no formal complaints made to the home since the previous inspection but there was a process in place to manage complaints should they be received. There were also systems in place to seek

feedback from people who lived at the home, relatives and staff.

Care staff and people who lived at the home told us that the home was well managed. Quality audits undertaken by the registered manager were designed to identify any areas of improvement to staff practice that would promote safety and optimum care to people who lived at the home. Staff told us that, on occasions, the outcome of surveys and audits were used as a learning opportunity.

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 had received training in the administration of medication and we found that people who lived at the home received the right medication at the right time.

Staff had been recruited following the home's policies and procedures, and there were sufficient numbers of staff employed to ensure people received a safe and effective service that met their individual needs.

Staff had received training on safeguarding adults from abuse and this meant they were aware of how to refer any concerns to the safeguarding authority.

The premises had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and people told us they liked the meals at the home.

People told us they had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the home and staff.

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

possible, with support from staff.

People told us that their privacy and dignity was respected and we saw evidence of this on the day of the inspection.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests and the people who were important to them, as well as their preferences and wishes for care.

People were encouraged to follow their chosen lifestyle and to take part in their chosen activities.

There was a complaints procedure in place and people told us they would be happy to speak to the registered manager or one of the care staff if they had any concerns.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission, and people told us the service was well-managed.

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

Quality audits were being carried out to monitor that staff were providing safe and effective support for people who lived at the home.

Shamrock House

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 23 March 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector and an Expert by Experience. An Expert by Experience is someone who has personal experience of using or caring for someone who uses / used this type of 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 and information we had received from the local authorities who commissioned a service from the registered provider. The registered provider submitted a provider information return (PIR) prior to this inspection. The PIR 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.

Healthwatch had carried out an 'Enter and View' visit to the home; Healthwatch is the independent consumer champion for health and social care in England. We reviewed the report completed by Healthwatch following their visit and some comments are included in this report.

On the day of the inspection we spoke with five people who lived at the home, four members of staff and the registered manager.

We looked around communal areas of the home and 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, including quality assurance, health and safety and medication.

Good

Is the service safe?

Our findings

We asked people if they felt safe living at Shamrock House and all five people who we spoke with responded positively. Comments included, "I get well looked after. I suffer from epileptic fits and they look after me", "Extremely safe – staff and safe environment" and "Yes, I trust the people here." Staff understood their responsibilities in respect of keeping people safe. One member of staff told us, "We make sure environment is safe – no trip hazards, help to seats, make sure comfy. We assist people up the stairs and offer assistance at mealtimes" and another staff member said, "We check everything is up to date such as risk assessments."

We saw there were risk assessments in place to advise staff how to minimise any identified risks. We saw risk assessments in respect of the use of bed rails, mobility and the risk of falls, medication, use of the stairs, food and drink, smoking, leaving the premises, self-harming, suicide and the risk of violence to others. These were scored to identify whether the level of risk was high, medium or low. Following completion of a risk assessment, one person had been provided with a special bed with bed rails to help reduce the risk of them falling out of bed.

We saw there were policies in place on safeguarding adults from abuse. The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. Staff were able to describe different types of abuse, and they told us that they would report any incidents or concerns they became aware of to the registered manager. They added that they would take the matter further if they were not happy with the registered manager's response. One member of staff told us, "I would report it to the manager or higher" and another said, "I would report it to the manager – if I wasn't happy, I would go to safeguarding."

We checked the folder where safeguarding incidents were recorded and saw that the threshold tool introduced by the local authority was being used. This helped registered managers determine when a safeguarding alert needed to be submitted to the local authority and when an incident could be managed in-house. We saw that this tool was being used appropriately.

We saw that the registered manager monitored any accidents and incidents that had occurred at the home. There had been three accidents in 2015; we saw that these had been recorded appropriately and that medical attention had been sought as needed. The registered manager told us that, because there were only a small numbers of accidents or incidents, any patterns that were emerging would be easily recognised.

Only senior staff were responsible for the administration of medication and the training records we saw confirmed that these members of staff had completed appropriate training. The staff who we spoke with confirmed that they carried out medication training each year to ensure they remained competent to undertake this task.

People's care plans included details of their physical and mental health conditions and their current prescribed medication. This included a detailed account of each medication, the reason it had been

prescribed and how it should be administered. People told us they understood why they were taking their medication and everyone we spoke with said that they received their medication at the right time. The senior staff member responsible for administering medication told us that medication was administered at 10:00, 14:00, 18:00 and 21:00, unless there were specific requirements for it to be administered at other times of the day.

We saw that medication was stored securely in the registered manager's office. The medication fridge was also in the same office and we saw that the temperature of the room and the fridge were taken regularly to ensure medication was stored at the correct temperature. Medication was supplied in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. None of the people who lived at the home had been prescribed controlled drugs (CDs). These are medicines that have strict legal controls to govern how they are prescribed, stored and administered. We saw that there was a storage cabinet and a CD record book should someone be prescribed this type of medication.

We checked the folder where medication administration record (MAR) charts were stored and saw that there was a list to record the name of the staff member who had been responsible for the administration of medication each day. Most MAR charts included a photograph of the person concerned although there was no photograph for one person. The registered manager told us that this person had refused to have their photograph taken. We saw that most handwritten entries on MAR charts had been signed by two members of staff, although two entries had only been signed by one person. The risk of errors occurring when information was transferred from the original packaging to the MAR chart would be reduced if the task was carried out by two members of staff. We saw that there were a small number of gaps in recording; these were primarily for creams rather than liquids or tablets. Some people administered their own creams; staff handed the creams to the person and completed MAR charts when the creams had been administered. Body maps identified where on the body the cream should be applied. Codes to record the reason why medication had not been taken had been used appropriately.

Some people had been prescribed 'as and when required' (PRN) medication and the MAR chart had only been signed when this medication had been administered. On these occasions, the reason for administration was recorded on the rear of the MAR chart. One person's care plan recorded about a PRN medication, "Strictly PRN – not to be given unless necessary" and we saw this instruction had been adhered to.

There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy, apart from when medication was prescribed mid-cycle. Staff told us that this would be addressed. There was a sheet in use to record medication expiry dates and staff told us that their policy recorded that all blister packs had to be returned to the pharmacy within 56 days. The arrangements in place for returning unused medication to the pharmacy were satisfactory.

The homes pharmacist had carried out an audit. They had made some recommendations, including that the National Institute for Health and Care Excellence (NICE) guidelines must be followed, that an up to date list of staff signatures was required, advice about the administration of Alendronic acid and to "Ensure that regular doses on the MAR always have an initial or an identifiable code." We saw that staff had listened to this advice; codes had been used appropriately to record when medication had not been administered.

We checked the recruitment records for two members of staff. We saw that an application form had been completed, references obtained and checks made with the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to

work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. We noted that, for one person, references had been received after their start date. The registered manager told us that this person had been on annual leave, carried out induction training and shadowed experienced care staff during the interim period. They said they would record such detail in future to show that people had not commenced work until all safety checks were in place. This would provide additional evidence that only people considered suitable to work with vulnerable people had been employed at Shamrock House.

People who we spoke with told us they felt there were enough staff employed at the home. One person said, "Yes, if you need someone you just ask and they will see to you." Staff also told us there were enough staff on duty. One staff member said, "Really good – we work well together and always cover" although another member of staff told us, "It depends on the day – [there is] more to do on certain days." The staff rotas showed that there was a minimum of three care staff on duty each morning, afternoon and evening; these staffing levels were increased to four on some occasions. There were two care staff on duty overnight, and the registered manager was on duty in addition to care staff. We checked the staff rotas for a two week period and saw that staffing levels had been maintained.

We checked that the premises were being maintained in a safe condition. We saw maintenance certificates for the electrical installation, portable appliances, gas safety, emergency lighting, door guards and fire extinguishers. In-house checks were carried out on the fire alarm system, emergency lighting and the emergency call system. The most recent audit on the emergency call system had identified that one alarm was not working and we noted that an electrician had been called out to repair the fault. There was a book to record in-house maintenance such as changing light bulbs and checking water temperatures and we saw that there was a record of when these repairs / checks had been carried out.

There was a fire risk assessment in place and fire drills were carried out each year for people who lived at the home and every two or three months for staff. This was to ensure that staff and people who lived at the home knew what action to take in the event of a fire.

We saw that there was a fire evacuation plan in place and that it had been reviewed in February 2016 to ensure it was up to date. This included personal emergency evacuation plans (PEEPs). These are documents that record the support a person would need to be evacuated from the premises, including the level of assistance they would require from staff. However, we noted that the PEEPs that had been developed at Shamrock House were more like individual fire risk assessments than records of the level of assistance each person would require to evacuate the premises. We also discussed how it would be useful to include information about other emergencies that could occur in the evacuation plan, such as flood, loss of utilities and an outbreak of infectious disease, plus important contact numbers.

On the day of the inspection we found the home to be clean and free from unpleasant odours. People who lived at the home told us the home was always clean and hygienic. One person said, "They keep it tidy for me."

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The people who lived at the home had the capacity to make their own decisions and discussions with the registered manager and staff indicated that they understood the principles of this legislation and how it applied to people who lived at Shamrock House. Care plans evidenced that there were occasions when people had difficulty making important decisions; in these instances, best interest meetings had been arranged to support people with decision making.

Deprivation of Liberty Safeguards (DoLS) are part of the 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. None of the people living at the home had a DoLS authorisation in place although the registered manager had submitted two applications to the local authority for consideration.

Two members of staff and the registered manager had attended training on MCA and DoLS. We saw information on the home's notice board indicating that further training on the MCA had been arranged for May 2016.

The registered manager told us in the provider information return (PIR) that one person who had been assessed as having the capacity to make decisions had agreed to relatives applying to the Court of Protection for an Enduring Power of Attorney (EPOA) over their finances, and care and welfare. This had been agreed as a result of a review arranged by the local authority. A Power of Attorney (POA) is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf.

The registered manager also told us in the PIR, "We do not operate a secure facility and have never in my 12 years at the home had to use any form of restraint." This was confirmed by staff who we spoke with. The registered manager told us that staff had completed training on 'challenging behaviour and physical interventions' and this guided staff how to deal with situations that had the potential to cause harm to people.

We saw that staff asked for people's permission or consent before they started to support them. All of the people who we spoke with confirmed that they were consulted about their care and that staff asked for consent. After lunch we saw that a member of staff asked someone if they would like to go back to their room, and the staff member supported them by handing them their walking stick and accompanying them to their room. People were invited to sign consent forms in respect of staff administering medication and to information being shared with appropriate people; some people had agreed to sign these consent forms and others had not signed them.

Care staff told us that they helped people to make decisions by offering them choices and asking them what support they need. Staff told us, "We ask them" and "Talk to them – ask what they would like to do." On the day of the inspection we saw that people went outside to have a cigarette whenever they chose to do so, and that some people went out (after telling staff where they were going and what time to expect them back home).

We asked people if they thought staff had the skills they needed to carry out their roles and to assist them with their care and support needs and they responded positively.

The records we saw confirmed that staff had completed appropriate induction and on-going training. Staff received a copy of the home's staff handbook and a code of conduct during their induction period, and shadowed experienced care workers. The registered manager told us that there were plans in place for each member of staff to commence the Care Certificate; this would be induction training for new staff and refresher training for existing staff. The Care Certificate is an identified set of standards that health and social care workers are expected to adhere to in their daily working life.

We saw that staff had received training that gave them the skills to carry out their roles effectively. Records showed that staff had completed training during 2015 and 2016 on fire safety, medication (including Warfarin, MDS and homely remedies), falls prevention, equality and diversity, diabetes awareness, safeguarding adults from abuse, epilepsy awareness and urinary tract infection (UTI) awareness. We noted that some refresher training was overdue. For example, some staff had not attended training on moving and handling since 2011. We saw information on the notice board recording that this training was arranged for May 2016.

Staff told us they were well supported. They said that they attended staff meetings once a month (on 'pay day') and had regular one to one supervision meetings with the registered manager. These are meetings when staff meet with a senior staff member or manager to discuss any concerns they might have, any training needs and information about particular people who live at the home. The registered manager told us that they aimed to have supervision meetings with staff six times a year, and the records we saw evidenced that this was being achieved. Records showed that staff were also observed whilst carrying out their day to day tasks so that the registered manager could monitor that they remained competent to carry out their role.

People told us that staff were aware of their special dietary needs and their likes and dislikes. One person told us that they had diabetes and that their dietary needs were met. Other people told us, "I like the shepherd's pie and fish on a Friday is alright too" and "It is lovely. I like a chip buttie and a good curry." Staff told us that people's dietary requirements were recorded in the food chart in their care plans and that they recorded what people ate each day. One member of staff told us they 'sat in' with people when they had meetings with the dietician and then recorded the outcome of the meeting in the person's care plan. This meant that the person's care plan reflected their current dietary needs.

The person cooking the meal on the day of the inspection told us that people's dietary requirements were not recorded in the kitchen. They said that all staff were aware of any special dietary requirements because they knew people's individual needs "So well." We discussed this with the registered manager who acknowledged that it would be helpful for this information to be recorded in the kitchen, and that this would be actioned.

We saw that there was a menu board in the hallway (an area accessible to everyone who lived at the home) that recorded the menus for that week. We observed the lunchtime experience and saw that people were

served with the main meal of the day. Earlier in the day we observed conversations between people who lived at the home and staff about the days menu, and noted that they were offered alternatives to the main meal. We saw that people were served with these alternatives. One person was encouraged to eat more as they had eaten very little. People were asked if they had finished their main meal before their plates were cleared away, although we saw that desserts were offered and served before people had finished their main course; this could have resulted in people feeling 'hurried'. We saw that a choice of drinks was provided at lunchtime and at other times of the day.

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.

When we read people's support plans we gained a clear understanding of each person's medical condition, the reason medication had been prescribed, how the person was able to manage aspects of their physical and mental health condition themselves and the level of support they required from staff and health care professionals.

We saw that any contact with health and social care professionals was recorded, including the date, which health care professional was seen, the reason for the contact and the outcome. This information indicated that care professionals such as the GP, psychiatrist, community nurse and social worker were involved appropriately in supporting people to reach optimum health and well-being. People confirmed that they could see their GP and other health care professionals when they needed to. Comments included, "I only have to ask" and "Easy [to see my GP] – dentist and optician if needed as well."

People had patient passports in place; these are documents that people could take to hospital appointments and admissions when they had difficulty verbally communicating their needs to hospital staff. We saw that patient passports included information about people's personality traits as well as their social and health care needs.

Some bedrooms were located on the first and second floors of the premises. Staff told us that it would be useful to have a stair lift, especially as people who lived at the home grew older. The registered manager had taken advice from an engineer, who had undertaken a structural survey and concluded that there was insufficient space for a stair lift to be fitted. People who lived at the home told us they did not have any problems mobilising around the home. There was a bathroom and a shower room and this meant that people could choose whether to have a bath or a shower.

Good

Is the service caring?

Our findings

We saw there was a monthly record of the time keyworkers spent with people, both at the home and out in the local community, for example, shopping, attending appointments and accompanying them to social events. Representatives of Healthwatch wrote in their 'Enter and View' report, "Everyone was going about their everyday lives, interacting with each other. It was a happy place" and, "We spoke to many of the residents who were all happy to speak to us and said that they like where they are. There was a lot of jovial banter between the staff and residents giving the feel those residents really do feel that this is their home."

We asked people who lived at the home if they felt staff really cared about them, and they all responded positively. One person told us, "Yes, if they didn't they wouldn't be here – they do anything to help you." Staff told us they were confident that the full staff team cared about the people they were supporting. Staff told us, "Very much so – one big family" and "Yes, it's like a big extended family here."

We saw that interactions between people who lived at the home and staff were positive; it was clear that there was rapport between them and that staff understood people's particular personalities, behaviours and support needs. We saw people approaching staff to tell them where they were going and what they were going to do. We noted that staff listened to people's comments and offered appropriate advice.

We asked people who lived at the home if staff respected their privacy and dignity and they confirmed that they did. One person said, "Yes, they knock on the door before they come in, and letters are unopened" and another said, "Yes, they don't open my post." Staff told us that they ensured a person's dignity was maintained when they assisted them by using dividers in shared rooms, talking to them in private and asking them where they would like to see their visitors. One member of staff said, "We always knock on doors and give them a choice of who helps them with personal care."

Staff told us they tried to encourage independence and supported people to carry out tasks that they were able to do independently, and only helped with tasks that the person found difficult. Staff told us, "A couple of gentlemen like to do their own washing and one lady likes to cook" and "We encourage them to do as much as possible for themselves." We observed this to be the case on the day of the inspection.

People who had visitors told us that their family and friends were made welcome at the home. Staff told us that they helped people to keep in touch with family and friends. Comments from staff included, "A lot of our residents are able to go out on their own – we encourage friends to visit and we invite relatives to parties and events", "[People who live at the home] nearly all have mobiles and we chat to their relatives" and "We have a phone they can use and they write letters – we are trying to set up Skype." This showed that staff supported people to maintain family relationships and friendships.

The registered manager told us that they were able to access information about advocacy services if people required or wanted this input, and that one person had a solicitor who acted as their advocate.

Discussion with the registered manager and staff and our observations on the day of the inspection

indicated that people had diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had diverse needs and that these were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

Three of the five people we spoke with said they were aware of their care plan and one person told us that their care plan was "Reviewed now and again."

We saw that assessments were undertaken to identify people's support needs, and that these were accompanied by risk assessments that recorded any identified risks. Information gathered in assessments and risk assessments was used to develop care plans that outlined how the person's individual needs should be met. Areas covered included personal hygiene, dressing, mobility, medication, contact with family and friends, mental health and social activity. Support plans were reviewed and updated each month so they were reflective of each person's current needs.

It was clear from reading support plans that care was focused on the person concerned. The support plans we looked at were written in a person-centred way and recorded the person's individual needs and abilities as well as choices and likes / dislikes. There was a record of the person's preferred name, their life history, their hobbies and interests, the people who were important to them, their medical conditions, their prescribed medication and the support they received from health and social care professionals.

Staff told us that they got to know about people's individual needs by talking to them and their family, and by reading care plans. They said that they had more time in the afternoon and that is when they were able to sit to chat with people. One member of staff said, "We sit down and talk to them – we listen to them." It was clear that staff understood people's individual personality traits, strengths, support needs, and likes and dislikes.

People told us there were activities they could take part in. Comments included, "I go out every so often", "[I play] dominoes and that is enough", "They [the staff] play dominoes and I do jigsaws" and "I go out shopping on my own." One person told us that they did not take part in activities and that was their choice. Some people told us that an organisation called Green Team were going to be involved with the home. They would be visiting the home to help people take part in gardening and, as a result, help them improve the garden area at the home. They told us they were looking forward to this.

Staff told us that they had more time to involve people in activities within the home in the afternoons, and one member of staff told us that staff often came into work in their own time to help with social events in the evening. Activities mentioned by staff included baking, playing cards and dominoes, sing-songs, jigsaws, attending Sobriety (a local community centre) and bingo. On the day of the inspection we saw a member of staff assisting someone to make cheese scones and another member of staff playing a game of Connect 4 with someone.

Care staff recorded information about each person during the day and night. Records included information about the person's physical and mental health, personal hygiene, food and drink, contact with family and friends, social activities and medication. Staff told us that information about each person's care needs was discussed at daily handover meetings; this was to ensure they had the information they needed to provide

responsive care as people's needs changed.

Four of the five people who we spoke with told us that staff shared information with them and communicated with them appropriately. One person said, "They talk to me in private, usually in the office" and another person told us, "They talk to me – one to one." One person felt that staff did not share information with them but they were not able to elaborate on this.

There was evidence that meetings were held for people who lived at the home and four of the five people who we spoke with told us that they were aware of these meetings. One person said, "We get asked what we like" and another person said, "I take part in residents meetings." Topics discussed at recent meetings included menus, entertainment, and a reminder to everyone that the home was a no-smoking building. People were asked about the menu and more suggestions for additions to the menu were discussed. People mentioned that some light bulbs needed to be replaced and there was a note to record that this work had been carried out.

Staff told us there were various ways people who lived at the home were consulted. One member of staff told us, "We ask about food – what they would really like. Also – things they would like to do and go to see." Another member of staff said, "At the last residents meeting we were asked for more choice on food and we have done this." Staff said that the views of people who lived at the home were always listened to. People told us they would speak to staff if they were not happy and particularly mentioned the registered manager as someone they would feel comfortable to talk to. One person told us, "I would tell [Name of registered manager] and she would sort it."

Staff told us that, if someone complained to them, they would initially try to resolve the problem. If they were not able to, they would report the issue to the registered manager. They said they were confident the person's concern or complaint would be listened to and acted on. Comments included, "I would try to sort it out but if not, I would report it to the manager", "Report it, write it down and see how we can resolve it" and "I would give them a complaints form and pass the info. to the manager."

We saw that the complaints procedure was displayed in the hall and the registered manager told us that all relatives had been given a copy. The registered manager told us that there had been no complaints in the previous two years, and that people who lived at the home were asked at every 'resident' meeting if they had any concerns or complaints.

Good

Is the service well-led?

Our findings

The registered provider was required to have a registered manager as a condition of their registration, and the service had a manager who was registered with the Care Quality Commission. This meant that the registered provider was meeting the conditions of their registration. The registered manager was the deputy manager prior to being promoted to manager and had worked at the home for several years; this provided consistency for the people who lived at the home.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection. We found that these were easily accessible, well-kept and stored securely, including people's support plans and other documents relating to people's care and support.

The minutes of a meeting for people who lived at the home recorded that the charter of rights was added to the notice board, and one person had requested that this be explained to them. The registered manager described the culture of the home as, "Homely – there are only 17 service users and staff know people 'inside out'. People can come and go as they please." A member of staff told us, "[The culture] is good. Everything is discussed at the end of each shift."

We asked staff if they thought the home was well managed and they all responded positively. Comments included, "Good – it is getting a lot better. I feel much more supported now", "A lot better than what it was previously – things are getting done" and "The manager is very fair and approachable." People who lived at the home told us, "She's very approachable – she listens" and "She works well and she helps everyone."

The most recent survey for people who lived at the home was carried out in June 2015. We saw the evaluation that had been carried out by the registered manager; this recorded, "For most part everyone is happy with the laundry and food. In response to losing socks, nylon laundry zip bags were purchased with names on so socks do not get separated in the wash. Meals all have an alternative; unless it is specified, we always offer a range of sandwiches or jacket potatoes." This showed that people's comments were listened to and action taken to make the suggested improvements.

Staff meetings were held on a regular basis. We saw the agenda for the meeting on 4 March 2016 and saw that the topics discussed included the role of senior staff, recording, the recent pharmacy inspection and staff training. The manager recorded, "If you haven't brought in certificates I cannot class you as having passed the course." Previous meetings had been held in January 2016 and October 2015. Topics discussed were individual fire evacuation plans, care plans, report writing and safeguarding adults from abuse; the minutes recorded that the manager had told staff, "If in doubt, ask for advice."

Audits were being carried out by the registered manager, including audits for health and safety and care planning. We saw that a care plan audit had been carried out in October and December 2015 and again in February 2016. These recorded any action that needed to be taken by staff to ensure that care plans included all of the required information.

Staff told us that any issues of concern would be discussed openly and they were certain that any learning would be identified, including whether any improvements were needed to make sure the same issue did not occur again. One member of staff gave us an example of an incident that had occurred and the action staff had taken to avoid a similar incident happening again.

Staff told us that they would use the whistle blowing policy if they needed to, and that they felt the registered manager would deal with any whistle blowing information professionally and confidentially.