Belford Care Limited

# Belford House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Requires Improvement |
| 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 10 and 13 October 2016. The inspection was unannounced. The service was last inspected in October 2013, when it was found compliant with the four outcomes inspected

Belford House provides care without nursing to up to 32 older people who are frail or who suffer from dementia. One bed is set aside for people on short-term respite care.

A registered manager was in place as required in the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt well cared for and said staff were supportive, kind and respectful of their dignity. They told us staff sought their consent before providing care and gave them opportunities to make choices in their daily lives. They described the service having a calm, relaxed atmosphere. People's opinion of the service had been sought through a survey which produced positive feedback.

People's rights and freedom were protected in the way staff worked with them. Staff knew how to keep them safe and what to do if they had any concerns about people being abused. People's complaints had been responded to and addressed.

We found some potential safety issues relating to the bathing facilities but these were put right during the inspection process. Some additional detail was also required in the guidelines for people who were prescribed medicines to be given only when required.

The staff rotas did not clearly identify the staffing levels and there were some shortfalls due to vacant posts which were being recruited to at the time of inspection. A programme was in place for staff induction and training and staff received ongoing support in their work.

Staff worked patiently and calmly with people, and knew them well, offering reassurance or assistance when required. People's health and nutritional needs were well managed and they were encouraged to make decisions and choices about their daily lives. The level of activities was acknowledged by the registered manager as an area to be improved. To this end the service was trying to recruit a new activities coordinator.

The registered manager was praised by people and staff found her approachable and supportive. The registered manager and providers had systems in place to monitor the operation of the service and the registered manager directly observed care practice to monitor this.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was safe for the most part.

People told us they felt safe and well care for.

Temperature control valves had not previously been fitted to bath and shower outlets which could have presented a risk to people. This was addressed during the inspection. The current temperature check records and some thermometers were also absent from bathing facilities but were reinstated during the inspection.

Medicines administration guidelines for as required (PRN) medicines were not always sufficiently detailed to safeguard people from the risk of an inconsistent approach by staff to their administration.

The full staffing levels were not clear from the current rota format and the registered manager described some changes made which were inconsistent with the levels stated in the Statement of Purpose.

### Is the service effective?

**Good**

The service was effective.

People were happy the service met their needs and praised the relaxed atmosphere. We saw staff providing effective support to people and engaging positively with them.

People's rights were protected in the way staff worked with them. Their health and nutritional needs were well managed.

The service had an effective induction and training programme. Staff development was supported through ongoing supervision meetings, annual appraisals and regular observations of care practice.

### Is the service caring?

**Good**

The service was caring.

People felt the staff were kind and caring.

People were treated as individuals and spoken to respectfully.

Staff knew people well and information about their history, preferences and interests was sought to support their care.

People were happy the staff respected and supported their dignity. People's spiritual needs were met and their wishes were sought about their care.

## Is the service responsive?

Good

The service was responsive.

People felt staff responded promptly to their needs and communicated well.

People were supported to make choices about their daily lives and had detailed care plans.

The level of activities was to some extent limited by reduced staffing levels and the absence of a person whose role it was to lead activities.

People's complaints had been responded to and a number of compliments had also been made about the service.

## Is the service well-led?

Good

The service was well led.

People felt the service was well led and praised the approach of the registered manager.

Regular meetings took place with staff and they felt the provider' and manager's aims and ethos of care were clearly communicated.

The registered manager and providers had systems to monitor the operation of the service and reviewed the progress made on identified issues.

People's views about the service were sought through regular residents meetings as well as via surveys. Where concerns had been raised, these were thoroughly investigated and the resulting recommendations actioned.

# Belford 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.

We last inspected the service on 4 October 2013. At that inspection we found the service was compliant with the essential standards we inspected.

This inspection took place on 10 and 13 October 2016 and was unannounced. The inspection was carried out by one inspector.

Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

During the inspection we spoke with three people in depth and two others more briefly, about their experience of the service. We also spoke with a visiting healthcare professional about the service.

We 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 also observed the interactions between people and staff and saw how staff provided people's support. We had lunch with people on the first day of the inspection.

We spoke with four of the staff, the administrator and the registered manager. Prior to the inspection we contacted the placing local authority to seek their views. They raised no concerns about the service.

We reviewed the care plans and associated records for four people, including their risk assessments and reviews, and related this to the care we observed. We examined a sample of other records to do with the home's operation including staff recruitment, supervision and support records, surveys and various monitoring and audit tools.

Requires Improvement

# Is the service safe?

## Our findings

People felt safe in the home and well cared for. One person said they were, "…absolutely safe here, more so than at home," others said, "Yes I feel safe" and "I feel safe."

Certification was in place confirming the required servicing of most equipment had taken place, except for the servicing of hot water temperature monitoring valves. It emerged that these were not fitted to bath and shower outlets as required. The registered manager arranged to have these fitted immediately and they had been installed on the second day of the inspection. The ongoing servicing of these valves will be checked at subsequent inspections.

The manager told us a system of temperature monitoring was in place prior to each use of bath or shower. However, we found these records were absent from bathrooms on the day of inspection as were the thermometers in some cases. These were reinstated at the time. Ongoing monitoring of bath and shower temperatures will be checked at subsequent inspections. The temperature of the hot water at each bedroom basin was checked and recorded monthly.

We saw that windows were fitted with restrictors for both security and safety.

The service was clean and was free of unpleasant odours. Appropriate laundry facilities were provided to reduce the risk of cross infection. However, the manual system of cleaning/sterilising commode pots in bedrooms was not in accordance with national guidance/best practice. The registered manager agreed to look into obtaining a commode pot sterilizer.

The registered manager told us people were able to manage their own medicines, subject to risk assessment, should they wish to do so. One person partially managed their medicines and another held their inhaler and self-administered this. Appropriate risk assessments had been carried out and ongoing monitoring was in place to identify if the person was no longer able to manage this themselves. Where the service managed people's medicines on their behalf, they were administered by the senior care staff during the daytime or by trained night care staff, where necessary. The registered manager told us six staff had completed their 'Care Certificate' medicines administration competencies and one further staff member was in the process of completing these. The registered manager said herself and one senior were booked on a course to enable them to deliver the medicines training in-house.

The service used a monitored dosage system which included pre-sealed, name-labelled pods for each medicine dosage time for both tablets and liquids. Records included individual medicines administration record (MAR) sheets together with a separate log of medicines brought forward, delivered and returned. The registered manager audited these records monthly and any issues were picked up with staff within seniors meetings. People each had individual medicines protocols and 'medicines administration preferences' sheets, describing their medicines and how they should be taken. Each person had a photograph with their MAR sheet and any known allergies were listed. Individual protocols for as required (PRN) medicines did not always include sufficient detail regarding the circumstances when PRN medicines should be given. For

example, in the case of a medicine prescribed to address agitation. The protocol did not detail any steps which should be tried first to avoid the need for the medicine, although these were included in the separate care plan.

Controlled drugs were recorded within an appropriate log and where they were administered by district nurses, they too completed the log book. Medicines fridge and medicine room temperatures were recorded daily and were within required limits. A blind had been provided at the window of the medicines room to assist with temperature regulation.

Staff knew what was expected of them should they be concerned anyone was at risk of harm. They told us they would report any concerns to the shift leader or manager. They told us management would respond appropriately but were aware of the whistle-blowing procedure if they felt an issue had not been addressed. The registered manager told us staff were encouraged to use it to raise any concerns they might have, which some had done previously. The training records supplied showed that all bar four of the staff had completed recent safeguarding training. The local authority were happy with the service in respect of safeguarding issues, of which none had arisen for at least the previous 18 months.

People's files contained relevant risk assessments and care plans to address identified risks to their safety, for example regarding falls, bedrails and manual handling. However, in one case a person with capacity, had been assessed as at risk of choking, but was reluctant to eat their food mashed. No risk assessment was in place regarding the choking risk to identify the risk level and guide staff on appropriate actions should this happen.

The service had a robust recruitment process which included the required checks of the character and suitability of potential employees. Personnel files contained evidence of these checks including a criminal records check, references, a heath questionnaire and a full employment history. Copies of documents confirming identity were also taken. In the case of agency staff, copies of information sheets provided by the external agency were obtained, to confirm they had completed appropriate checks and identify recent training.

The service had one day care staff vacancy and was due to have two further care staff vacancies due to in-house promotions. The registered manager told us that recruitment interviews were booked to try and fill these posts. The registered manager told us she also worked some shifts where cover was short.

The service was staffed with a mixture of long-term staff and more recent recruits. Agency staff had been used from two regular agencies when staff numbers had dropped, in order to maintain staffing levels. The registered manage told us that they had mainly used two regular agency workers to maximise consistency, mainly on nights and at the weekends. People and staff gave mixed feedback regarding the effectiveness of agency staff in maintaining consistency. Some felt they did not assist with this and were at times, unreliable. The service was also seeking a part-time activities coordinator as this vacancy was having some impact on the level of activities. The registered manager told us where performance issues had arisen regarding staff, these had been addressed with the relevant individuals.

We discussed with the registered manager, some anonymous concerns reported to us regarding night time staffing and care. The registered manager said she had worked at night on occasions herself and had carried out night time checks. She said she had held regular meetings with night staff where no issues had been raised about excessive workload. She described tasks such as laundry and ironing, which were commonly part of night staff duties. The registered manager told us the night-time staffing of two waking night staff, was maintained every night and had been arrived at following assessment of people's night-time care

needs, which were reported to be low. Where people preferred to get up early, once awake, this was enabled to reduce the risk of falls, should they try to get up unaided. The registered manager told us no one would be woken early unless it was their choice. A head of night care post was being recruited to, in order to further improve oversight of night-time care.

The registered manager told us only one person required assistance to transfer by means of a hoist. Based on individual dependency assessments the registered manager said daytime staffing was four care staff and a senior in the morning and three care staff and a senior for the afternoon and evening, plus ancillary staff. This matched the staffing levels stated in the most recent statement of purpose, dated April 2016. However, the rotas provided showed some shortfalls beneath these levels. The registered manager told us afternoon and weekend staff reductions had been based on her assessment of reduced needs at these times because baths were generally not provided at weekends. Also on some weekdays a morning care staff stayed on into the afternoon in an activities leader role, however, this was not explicit on the rotas. The apparent morning shortfalls were partially covered by one further staff member who provided support with meals and drinks but did not provide personal care. Additional care staffing was still being sought in terms of two further care staff posts which were being recruited to, which would provide for more comprehensive staffing, especially once a new part-time activities leader was recruited.

A detailed emergency/business continuity plan was available. This included details of the alternative premises for evacuation, should this be required and the action to be taken in the event of lift breakdown. Staff and management contact numbers were included together with the contact numbers for various mains services and repairs and the location of stop valves and electrical supply panels. The plan also included instruction for dealing with expected or unexpected deaths, the fire evacuation procedure and guidance on responding to falls.

Good

# Is the service effective?

## Our findings

People were positive about the service and the support provided by staff. One person said, "I get on with all of the staff", and confirmed staff always sought their consent to provide care. Another person explained, "staff asked what support I needed" and added, "I have never been so happy as here". They said the staff responded promptly to the call bell. Another person described the home as having a, "Happy atmosphere." One person commented that the agency staff were not as effective and they preferred the permanent staff who knew them.

People and staff described the home as tranquil and, "A home from home." They told us people could bring in items of their own, including furniture to make them feel more at home. People's feedback about care staff in residents meetings, was also positive as was feedback from the local authority. A representative said they were "Very satisfied with the level of care provided."

We observed staff interacting with people in a relaxed and friendly way, with smiles on their faces, encouraging them to communicate and engage with activities. People were offered gentle encouragement where required, to take drinks. One person was reading a newspaper and was left to do so uninterrupted except for being provided with a cup of tea. Once they had finished reading, staff greeted and engaged with them periodically when coming in and out of the lounge. No staff were based in the lounge during the 45 minute observation but they came in and out regularly to check on people and interacted with those who were awake. Some people chatted briefly amongst themselves, others watched the TV or dozed in their chair. A member of staff had a longer chat with one person about the hairdresser and an impending family visit. One person who got up to go to their room, appeared a little disoriented and a member of staff guided them there sensitively. We saw that although staff seemed busy, they made time to check on people regularly in the lounge and greeted them by name and provided refreshments.

One staff member was the lead person for training, for 18 hours per week. Since April 2016, new staff had been working towards the 'Care certificate' national award, although the registered manager said they were finding it took more than 12 weeks to complete. New staff received support and mentoring from a more experienced colleague during their three month probationary period, which could be extended if necessary to allow the staff member more time. For existing staff, they had worked through the same checklists to identify any training gaps and had identified where some additional training was needed or wanted by individuals. Staff confirmed to us they were working towards the Care certificate and that they were observed as part of this, to ensure their competence.

A senior had recently completed their training to enable them to deliver moving and handling training to staff. A course was scheduled for staff later in the month of inspection when each staff member would be observed, before being signed off as competent. Two care staff were being trained in readiness to become senior care staff. Staff told us that the service provided regular training to keep them updated and they had the opportunity to go on to do recognised qualifications such as National Vocational Qualification (NVQ).

Staff received one to one supervision, usually every three to four months. Staff were also subject to regular

observations of care practice as part of their supervision and competencies under the 'Care certificate'. The registered manager told us staff could also ask for time with her or other senior staff as and when needed. Staff had annual performance appraisals, which were due in November 2016. Staff could call the manager or administrator, on a rota basis out of office hours, for advice.

The registered manager told us around 70% of people could take an active part in planning their own care. Initial assessments always involved the prospective resident initially, with additional information being sought from family if necessary to complete 'life booklets'. These provided useful life history and other information, with the person's consent, to enable staff to engage more effectively with them. People's care files contained their consent or that of their representatives to various aspects of their care plan. Staff were clear they always sought people's consent before providing care. One said, "I always ask people re consent before giving any personal care."

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.

Discussions about mental capacity had taken place with staff in team meetings as well as attendance on relevant training. The service sought copies of power of attorney (POA) where others had been granted the right to make decisions on people's behalf, to evidence this. Two people had family members with POA for treatment and welfare. However, copies of POA had not always been sought where this was for financial affairs only. The service had challenged GP's where decisions on resuscitation had been taken without appropriate discussion with a person or their representatives. People's wishes regarding resuscitation were known and recorded.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberties Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive people of their liberty were being met. The service was compliant and working within these principles.

Due to people's dementia needs, the installation of a keypad on the front door was being considered. The DoLS implications had been considered. The DoLS assessor was due to visit the service to complete a DoLS audit, following five recent applications on behalf of people in the service. Another application was in process.

Where people did not have capacity but had no one with power of attorney, appropriate best interest discussions had taken place, involving appropriate others including healthcare professionals and family. One person had been assessed as at risk from falls from their bed. Appropriate best interest discussions had taken place to agree the provision of a bedside mat and alarm. Other appropriate best interest decisions had also been made to reduce identified risks, including a change to a medicine in liquid form and other medicines changes.

Each person was assessed for any risk of malnutrition or dehydration and nutritional care plans put in place where required. People were supported to maintain a healthy intake, sometimes using supplements, with the advice of a dietitian when required. At the time of this inspection no one required detailed daily monitoring of their intake of food or fluids, although everyone was weighed monthly to monitor for any

changes which might indicate a concern. The speech and language therapy team had been consulted for one person who was experiencing swallowing difficulties.

Staff reported people were generally happy with the meals and there were few complaints about it. People had a choice at each meal and additional alternatives would be provided if they didn't like the menu options on the day. Special diets were provided for including gluten free, vegetarian and diabetic diets as well as people's individual preferences. People were positive about the meals and choices. One person said they had, "…a choice of meal from the menu. The cook comes round and you can ask for additional items. Can have a cooked breakfast too." Another person told us, "The meals are good, we have a very good cook. The cook offers a choice daily and I can choose my own preferences too." This was also reflected in peoples feedback recorded in residents meeting minutes which was mostly positive and suggested the service responded whenever issues were raised about the meals and addressed them.

People were positive about the healthcare support they received. One person said they had kept their own GP and they were, "…called in promptly if necessary or if you asked." Another was taken by staff to regular hospital appointments and valued this support. Another person told us, "They call the doctor quickly if needed."

Feedback from healthcare professionals was positive. The service was said to work well with the local 'proactive care team', the mental health team and to alert the district nurse team promptly when there were concerns. Staff were described as very caring and the premises as very homely and the service was said to provide effective respite care support.

The service linked well with the district nursing team who also supported them where people required insulin injections for diabetes. They had provided staff training on responding to emergencies for people using insulin and staff were awaiting sign-off of their competency to administer emergency medicine to people dependent on insulin.

People's care files included records of regular medical appointments and evidence of prompt response to any health concerns. The registered manager told us that wherever possible they encouraged people staying on respite to retain control of things like their medicines, so as not to de-skill them for when they returned home afterwards.

The service was light and decorated in a homely style. The provider had recently added an additional six bedrooms with ensuite wet-room showers, backed up by a significant enlargement of the dining room. Alternative lounge spaces were available, providing people with a choice of communal areas. A computer was provided for those people able to use it, to enjoy video calls with family.

The registered manager told us the bathrooms were the next area due for refurbishment. Two of the bathrooms were rather cluttered with equipment and the registered manager acknowledged the service lacked storage for equipment which needed to remain readily accessible.

The service catered for people with some degree of dementia. However, adaptations to assist people to remain oriented, such as dementia-friendly bathroom and toilet signage, distinctive corridor décor and bedroom door identification were not consistently provided. The registered manager said people were offered the option of an individualised bedroom door name plate and we saw examples of this having been provided. One corridor in particular, was decorated with distinctive wall ornaments which would assist its occupants to identify it. Improvements were in process to make the garden more secure and accessible, including the provision of a new patio, paths and additional seating.

Good

# Is the service caring?

## Our findings

People were positive about the care and support by permanent staff. One said, "They are all good, I can't fault them" and added that their views were always sought. Another person described how they had been taken to visit several homes by their family, before choosing Belford House. They went on to say, "I have never known such kindness" and "I get on with all of them." Another person told us, "Staff are very helpful in every way, all very friendly" and added that there was, "…a nice atmosphere."

Staff treated people as individuals. They spoke to them with respect, used appropriate titles and their approach varied appropriately to reflect people's needs. Staff told us they got to know people well through conversation where possible and their 'life booklets'. They then used their knowledge to help them relate to the individual. They told us they used personal care as an opportunity to chat to people. We saw staff often took the opportunity to greet or acknowledge people when passing which helped them to feel valued as well as providing opportunities to request assistance.

We heard that at times, call bells were sounding for up to three or four minutes. The registered manager said people each wore an emergency pendant with which they could summon help anywhere in the service in an emergency. She acknowledged that people had grown used to using the call system for non-emergency issues at times, which could place an additional burden on staff when responding to non-urgent calls.

As part of the admissions process people were asked to provide whatever information they wished to for a 'life booklet'. This was used to identify their interests and preferences and aspects of their lives to date which staff might refer to in order to help them to engage with people.

People's spiritual needs were explored during the initial assessment and where people identified a wish to do so, opportunities for worship were provided within and outside the service. The pastoral team from a local church visited the service regularly. One person told us their spiritual needs were met by the visiting clergy and said they would be supported to attend an outside service if they wished.

People were encouraged to eat together in the dining room to promote social interaction and combat isolation but could choose to eat in their bedroom if that was their preference. Staff took some part in leading activities for people when they had time, particularly pending the recruitment of a part-time activities leader. However, staff were busy in the mornings providing personal care and supporting people's toileting needs so would not always have the time.

People had been asked whether they had a strong preference regarding the gender of the staff providing their support. The registered manager said three people did not want care support from male staff but that others had not expressed a preference when asked and added that the male staff appeared popular and people generally got on very well with them. In order to address people's wishes, staff of both genders were rostered on all shifts.

People praised the way staff supported their dignity. One said, "They are good with dignity". People's dignity

was upheld in the way staff worked with them and asked about their care needs discreetly and personal care was provided behind closed doors. People were actively reminded re using the toilet to promote continence and improve dignity. People could choose to have their bedroom door open during the day if that was their preference. One person confirmed to us that staff enabled this for them. At one point we saw a member of staff stop and take the time to remove a clothing protector from a person sat in the lounge, who had finished their food, so they were not sat wearing it unnecessarily.

The daily records we saw were written in a way which was respectful of people's individuality. Staff had received training on respecting people's dignity which was also discussed in team meetings. A 'Ten principles of dignity' poster was displayed as a reminder. Staff displayed a good understanding of dignity. As one staff member explained to us, "We are in their home". Other staff members described they ways in which they helped to safeguard people's dignity when providing personal care. These included keeping people as covered as possible, working behind closed doors and curtains and checking the person was comfortable to go ahead. People all had ensuite or dedicated toilets and six bedrooms had ensuite showers to further enhance dignity.

Where people had opted to complete end of life care plans their views or those of authorised representatives were recorded clearly so they could be respected when the time came. Some people had opted not to discuss their end of life wishes and this was respected, but re-visited periodically so that necessary information could be obtained. Where people had forms stating they were not to be resuscitated in the event of heart failure, the forms noted that discussion had taken place with the person or their representatives regarding the decision.

Good

# Is the service responsive?

## Our findings

People were happy with the responsiveness of staff. One person said, "They respond quickly and would listen to any preferences." Others said the same. The person gave the examples of their wishes for the times they were supported, being adhered to. They added that staff usually passed on information well, but said agency staff may not always do so. Another person told us, "I can chose any meal daily, they [the staff] are wonderful. If you say you'd like something, they provide it." A person said, "My independence is important" and told us the staff supported this. They also preferred to get up early in the morning and said the night staff supported them to do so. One person said of staff, "They notice things and they listen to how you like things done."

People had detailed care plans which included information about their life history as well as current needs, in order to support individualised care. Care plans made reference to people's wishes, preferences and consent and were regularly reviewed. People confirmed to us their views and preferences had been sought. The care plans were supported by risk assessments where necessary to minimise identified risks. Files included evidence of appropriate consultation with external healthcare professionals such as doctors, district nurses and dietitians.

The registered manager acknowledged that the provision of a greater range of activities was a priority. At present one of the care staff stayed on some afternoons to provide some activities, at other times this relied on care staff having time within care duties to initiate them, which meant opportunities could be limited. A new part time activities leader was being recruited for at the time of inspection to address this. People and staff commented that activities were improving.

Activities that had taken place included twice monthly minibus trips to local places of interest, garden centres, pubs, the supermarket or the seaside. People confirmed these events and some had taken part in them. Small animals had been brought in such as guinea pigs and owls, and staff sometimes brought their dogs in. Outside people visited to lead exercise and Tai chi sessions and a manicurist also visited the service. Seasonal events such as Easter, were celebrated as were people's birthdays. A photo album available in the entrance hall showed people engaged in various past activities. The member of staff who led some afternoon activities, provided a knitting club and one for card games. People mentioned both of these activities to us in conversation. One person said they would like more exercise sessions and felt it would be nice if activities and outings were publicised more in advance. There were plans for a possible 1940's themes event with appropriate music and for obtaining more memorabilia to encourage reminiscence.

People were provided with opportunities and supported to make day to day choices about their activities, where they spent time, meals and clothing. People's feedback confirmed this was the case and they gave examples such as their wishes about participation in activities and their meal preferences.

People were aware of how to complain if they were concerned about something and were happy that things which had been raised had been addressed. One person told us, "Issues were sorted out when I raised them." Another person said they had, "Not had to complaint but [the manager] would sort it out. All the staff

say, "we are here to help"."

The service had an appropriate complaints procedure which was posted in the entrance hall and included in the statement of purpose given to people and their families and in the contract. The registered manager told us the procedure was also explained to people on admission.

A suggestions book and comments/compliments book were also available in the entrance hall. We noted a number of recent positive comments in the comments book, regarding the care provided by the service. In response to a suggestion made, people now had the option to have their hot drinks in a mug instead of a cup and this had proved popular.

Periodic residents meetings took place where people were consulted about the service provided and asked for their views. Suggestions for outings arising from these meetings had been taken up.

The record of complaints and comments included two recent complaints which were addressed with the staff. The record lacked some of the detail which was provided verbally by the registered manager. There were a number of compliments and expressions of gratitude about the quality of the care and support provided. A suggestion made for the provision of an additional handrail in a toilet had been actioned by the service.

Good

# Is the service well-led?

## Our findings

People were positive about the way the service was led by the management team and the directors. One person described the registered manager as, "Wonderful, absolutely marvellous" and added that "She sorts things out, if she says she will do it, she does, a good manager." Another person described the manager as, "A good listener."

Communication between team members was supported by the 'general record' book completed daily, which functioned as a handover record, to ensure key information was passed from shift to shift. This included such things as changes to people's care plans or the outcomes of GP or district nursing visits.

General staff meetings occurred between monthly and quarterly with six having been minuted in the last 12 months. Minutes showed discussion of relevant topics such as training as well as discussions of care-related aspects or legislation. Seniors meetings had happened seven times in the previous 12 months to discuss relevant management issues. Periodic meetings had also been held between the registered manager and department heads. Night staff meetings also took place to ensure the night staff were kept fully involved and up to date with any changes or issues. Five had taken place in the previous 12 months.

Staff told us the provider's care ethos was made clear to them. They felt it was reinforced by the registered manager and the directors, some of whom visited the service regularly and spoke with staff as well as management. One member of staff told us the new owners were more involved and had invested more in the service citing the garden, bedroom and dining room developments.

During the inspection we saw staff and management relating well together, and staff spoke respectfully to each other in the course of their work. Although the atmosphere was calm and unhurried and staff went about their work with a smile, they were clearly busy and current staff shortfalls impacted on their individual workload.

Staff felt that teamwork and spirit was good and told us staff worked together. Staff confirmed regular team and other meetings took place to discuss the service and staff could raise issues or questions. One staff told us, "team meetings are constructive and you can speak up. I am comfortable to voice opinions". They added that if issues were raised, they were dealt with, and praised the teamwork. Another staff member said team meetings were "…positive and all have a say with the manager." Another staff told us team meetings were a, "…positive process and [you] can raise any issues." They added that management were supportive. Staff we spoke with felt respected by the registered manager and described her in positive terms. One staff member described her as, "Brilliant, respectful and professional." Some concerns were raised with us immediately following the inspection for which the provider commissioned an external investigation. This was good practice to ensure a full and thorough investigation. The investigation found the majority of issues to be unsubstantiated. Action was immediately taken to address the recommendations which resulted from the investigation report.

The registered manager said she carried out spot check visits out of hours and worked care shifts from time

to time as part of monitoring the quality of care. This also allowed her to understand any issues or difficulties being reported by the staff, and whether staffing levels were sufficient.

The registered manager completed monthly management audits and met regularly with representatives of the directors to discuss the service and developments such as the recent premises improvements and the planned bathroom refurbishment. As part of monthly audits the registered manager monitored such things as accidents and falls, which occurred infrequently. Monthly audits included a specific focus, based on a written schedule, which included regular monitoring of key areas like medicines, infection control and call bell responses. Each audit included an action sheet and documented any resulting actions. Where necessary issues identified were discussed in the seniors meeting, for example in the case of a series of issues from medicines audits. One off audits of key areas had also taken place. For example, an audit of the condition of mattresses had occurred in June and July 2016.

Some external audits also took place periodically of areas of care such as health and safety, medicines and fire safety. A mental capacity audit by the local authority was due to take place in November 2016.

People confirmed their views had been sought informally and through surveys. One said, "Surveys, yes and any issues I would tell [the manager] and she'd sort it out."

A survey of the views of people supported by the service, their relatives and external professionals, was carried out in June 2016. Feedback from three external healthcare professionals was positive. A summary of the findings from the survey of the views of people and relatives was produced. The feedback was positive with the only area identified as requiring improvement being activities provision.

Regular residents meetings had also taken place every three months. The minutes indicated discussion of a range of key areas including menus, activities, staff changes and proposed redecoration. Action sheets identified any action agreed at the meeting and when completed.