Veatreey Development Ltd

Ascot Lodge Nursing Home

Inspection report

38 Chambres Road
Southport
Merseyside
PR8 6JQ

Tel: 01704538470

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14 September 2016

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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 unannounced inspection of Ascot Lodge Nursing Home took place on 13 & 14 September 2016.

Ascot Lodge Nursing Home is situated in a residential area of Southport and is close to local amenities and public transport links. It provides accommodation and nursing care for up to18 people. Accommodation includes two lounges, 12 single bedrooms and two double bedrooms. A nurse call system is in place along with facilities to accommodate wheelchair access and for people with limited mobility. There is an enclosed garden and patio at the rear of the premises and car parking space to the front.

A registered manager was in post. 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 said they felt safe living at the home and were supported in a safe way by staff. This view was supported by relatives we spoke with.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. An adult safeguarding policy and the Local Authority's safeguarding procedure was available for staff to access.

Staff sought people's consent before providing support or care. The home adhered to the principles of the Mental Capacity Act (2005). Applications to deprive people of their liberty under the Mental Capacity Act (2005) had been submitted to the Local Authority.

Systems were in place to ensure medicines were managed safely. People told us they received their medicines on time. Staff were trained to administer medicines safely to people.

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults.

There were adequate numbers of staff on duty to provide care and support to people when they required it and wished to receive it. Calls for assistance were answered promptly.

Staff received training and support so that they had the skills and knowledge to care for people safely and in accordance with their individual need. People we spoke with and relatives confirmed this when discussing staff expertise.

People's care needs were recorded and care documents provided information for staff to follow to ensure people received the care and support they required.

Risks to people's health and wellbeing had been assessed and measures were in place to minimise risks to people's safety. Risk assessments and associated care plans were reviewed each month to reflect people's changing needs.

Staff worked well with health and social care professionals to make sure people received the care and support they needed. Staff made referrals to healthcare professionals for advice and support at the appropriate time.

Staff had a good understanding of people's needs and their preferred routines. We observed positive and genuine warm engagement between people living at the home and the staff throughout the inspection.

People told us they enjoyed the meals. The provision of more fresh produce was discussed on inspection along with the provision of more social activities for people to join in with. The management team has responded positively advising us of the purchase of more fresh food and introducing a new activities calendar.

There was a maintenance programme and arrangements in place for checking the environment and equipment was safe.

The culture within the service was open and transparent. Staff told us management was both approachable and supportive and that they felt listened to and involved in the development of the service.

A procedure was established for managing complaints. Complaints received had been responded to and appropriate actions had been taken.

Quality assurance systems were in place to ensure people received a well-managed service. This included audits (checks) on how the service operated. Feedback from people living at the home and relatives was also obtained by meetings, satisfaction surveys and daily discussions with the staff; people told us they were invited to share their opinions and views about the service.

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.

Medicines were managed safely in the home. People told us they were given their medicines on time.

Risk assessments had been undertaken to support people safely and in accordance with individual need.

Risks associated with hazards such as slips, trips and trailing wires were recorded as part of the service's health and safety measures to keep people safe.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

During the inspection there were enough staff on duty to provide care and support to people living in the home.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff received training and support to carry out their role effectively.

Staff sought the consent of people before providing care and support. The home followed the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions.

People were offered nutritious meals and they told us they enjoyed the food served.

People had access to external health care professionals to ensure their health and wellbeing.

Is the service caring?

Good

The service was caring.

People at the home told us they were listened to and their views taken into account when deciding how to spend their day.

People told us staff were kind, caring and respectful in their approach. We observed positive interaction between the staff and people they supported.

Staff treated people with respect, privacy and dignity and had a good understanding of people's needs and preferences.

Is the service responsive?

Good

The service was responsive.

There were activities planned and agreed for people living in the home and the registered manager agreed to develop these further to provide people with a more frequent and varied programme.

Care plans provided information to inform staff about people's support needs.

Staff worked well with health and social care professionals to make sure people received the care and support they needed.

A process for managing complaints was in place. People we spoke with knew how to raise a concern or make a complaint.

People living in the home told us they were able to share their views and were able to provide feedback about the service.

Is the service well-led?

Good

The service was well led.

Staff and people living in the home told us the service was well run and the registered manager was approachable.

Staff spoke positively about the open and transparent culture within the home. Staff said they felt included and involved in the running of the home.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it.

Quality assurance systems were in place, including audits (checks) to help monitor and improve the service.	

Ascot Lodge Nursing Home

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 team consisted of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We contacted the commissioners of the service to see if they had any updates about the home.

During the inspection we spent time with eight people who were living at the home. We spoke with a total of nine staff, including the area manager, registered manager, a registered nurse, two care staff, a chef, maintenance person and member of the domestic team. We also spoke with six relatives and sought feedback about the service with three external health care professionals.

We looked at the care records for four people living at the home, three staff personnel files, medicines and records relevant to the quality monitoring of the service. We looked round the home, including people's bedrooms, the kitchen, bathrooms, lounge, dining room and external grounds.

Good

Is the service safe?

Our findings

The people we spoke with who were living at the home told us they felt safe when being looked after by the staff. People's comments included, "I feel totally safe here" and "Yes, totally secure." Relatives said," If we felt it was not safe, we would have not moved (family member) here", "I have no concerns with safety here", (family member) is totally happy here and I know (family member) is safe here", "Generally care is good, not seen anything untoward" and "Yes, safe here but need more stimulation."

We talked to people at the home and their relatives about the staffing levels. People we spoke with told us they thought there were enough staff to deal with their needs and whilst the staff might sometimes be busy, they were always friendly and came as soon as they could. People told us, "They (staff) will sit and talk when they have time", "There are enough staff to support me", "Just here when I need them" and "A staff member always pops out and has chat in the garden with me and checks on how I am doing."

Relatives had mixed views about the staffing levels, "I can always find a member of staff if I need one", "Never had any trouble with the staff", "There seems times when there are not always any staff in the lounge", "Could do with another couple of staff, only occasionally need more staff in the lounge" and "Staff always seem to be available."

With regards to the security of the home. A relative told us that they noticed that the front door was always kept secure and staff let relatives in. They appreciated that this was to keep people safe and they 'felt better too about this' as strangers could not wander in.

We talked to people about their medicines and how they were managed. People told us they had their medicines on time and were given painkillers when they needed them. A person told us the staff were proactive in contacting their general practioner (GP) to arrange alternative medication when this was needed. Two people told us the staff gave out medication in a little cup and watched whilst it was taken; this helped to show the safe procedure staff followed when administering medicines.

We looked at the service's staffing arrangements. During the day the home deployed, three care staff, one nurse and/or the registered manager, a cook, a domestic member of staff and maintenance person. This was reduced to one registered nurse and member of the care team at night. Staffing levels took into account people's assessed needs; during the inspection a person was admitted and the staffing numbers were increased to four care staff in the mornings to support the 17 people accommodated. The staff we spoke with said there was sufficient staff on duty to meet the needs of the people living at the home. A staff member said, "The manager will provide us with more staff if this is necessary."

We noted that staff checked on people in the lounge/dining area and in their rooms to ensure their comfort and wellbeing. A number of people preferred to remain in their own room and staff told us how they completed hourly checks to ensure their comfort and safety. Staff told us the importance of conducting these checks particularly for people were not able to ring their call bells for assistance due to their frailty or poor health. During the inspection there was a member of staff in the lounge and another two staff members

visited people in their bedroom to provide care, meals and drinks. Records seen confirmed these hourly safety checks took place.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. An adult safeguarding policy and the local area safeguarding procedure was available in the home for staff to access. Information relating to safeguarding was also displayed. Safeguarding training had been given to staff and staff we spoke with told us they would always report any concerns to the manager and were aware that they could report outside of the organisation if they had to. A staff member was asked what they would do if they saw someone being mistreated. They said they "I would alert the manager first to let them know what had happened and what they were going to do, then contact safeguarding following the policy on the noticeboard."

We discussed with the registered manager and area manager alleged incident which occurred earlier in the year. The correct procedure had been followed for reporting to the local authority. Supporting records around actions taken lacked detail though both the area and registered manager were able to tell us the actions that took place and how they intend to improve the recording of such incidents. There were no further actions by the safeguarding team and the case has been closed.

During this inspection, we looked to see if there were systems in place to ensure the proper and safe handling of medicines. We found medicines were being managed safely.

People at the home had their medicines administered by the staff. People had a plan of care which set out their care and support needs for their medicines which included medicines to be given 'when required' (PRN). A protocol and form was in place for nurses to complete when giving PRN medicines. Some of these forms had been archived when the care documents had last been reviewed however the registered manager was able to show us the forms. These were returned to the 'working care file' for staff to refer to.

Medicines were securely locked away when not in use. A medication policy was in place and the nurses had recently completed medicines training to update their knowledge and skills for the safe management of medicines. The area manager told us they completed visual checks to ensure staff administered medicines safely. We discussed recording these checks as part of monitoring medicine management. The area manager said they would carry this out.

Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. Although there were no medicines that needed to be stored in the drug fridge at this time checks of the temperature had previously been recorded to ensure it was safe to use.

Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation.

We checked a selection of medication administration records (MAR) and found staff had signed to say they had administered their medicines. Quantities of medicines received into the home had been recorded and staff completed a stock balance check prior to administering medicines. This helped to ensure an accurate record was kept of medicines. We checked some stock balances and found these to be correct. A photograph was in place on people's MARS for identification purposes.

We looked to see if creams were applied as prescribed. We found cream charts were in place though these

did not always identify the area of the body that the cream was to be applied to. Staff we spoke with were able to tell us the areas creams were to be applied and the registered manager updated the cream charts during the inspection to reflect this. A person told us the staff supported them with their creams each day.

Nutritional supplements were given as prescribed for people who had a poor dietary intake. The use of thickening agents was also recorded and signed for on the MAR. Staff were aware of the number of scoops to be added to drinks to reduce the risk of the wrong consistency of fluids. Using the wrong consistency could increase the risk of choking or lead to aspiration which is when fluid can enter the lungs.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at three staff files for newly appointed staff. We asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. Checks had been made so that staff employed were 'fit' to work with vulnerable people.

We found during our inspection that people were assessed for any risks regarding their health care needs. These included areas of risk such as falls, moving and handling, nutrition and skin integrity. The risk assessments were reviewed and the information used to formulate a plan of care. A process was in place for recording incidents such as falls.

Systems and processes were established for checking the safety of the water, fire systems, emergency lighting and equipment. Service level agreements were established for moving equipment, heating, lighting, electrical, gas and lift checks. A personal emergency evacuation plan (often referred to as a PEEP) was in place for each of the people living at the home so that they could be evacuated safely and efficiently in the event of an emergency. These were located in people's care files. Fire evacuation procedures were also displayed in prominent areas.

We saw the service's fire risk assessment of the building. This had not been updated for over a year following work which had been completed to improve fire safety and also to reflect information requested by the fire service for recording evacuation procedures and general fire precautions. These procedures and precautions were included in the fire training for staff. During our inspection a fire safety contractor visited the home and conducted a review of the fire risk assessment. A new fire risk assessment was being drawn up for the service.

Risks associated with hazards such as slips, trips and trailing wires were recorded as part of the service's health and safety measures to keep people safe.

When looking round the home we found it to be clean and subject to monitoring checks to ensure adherence to control of infection. Staff had access to gloves, aprons and liquidised soap to assure good standards of hygiene.

Good

Is the service effective?

Our findings

People living in the home told us they enjoyed the meals. People said, "Food is good, you get enough to eat and drink", "Caring man, the chef" and "If I don't like something, the chef will go and find me something else."

Relatives told us they could have a meal with their family member and that they were always offered a drink when they were visiting. Their comments included, "Great cook, if I had made it, (family member) wouldn't have eaten it", "Sunday dinner is beautiful, asked for seconds", "Yes, there is enough to eat and it's reasonable quality, (family member) has put on weight" and "The chef usually makes them (residents) something special if they (residents) don't like the menu."

People told us they could see their GP when they wanted and staff were prompt in seeking an appointment for them. One person said, "GP was called when I had problem with my stomach after taking painkillers; they came out straight away."

People and their relatives thought the staff were trained to support people and ensure they received appropriate support from external professionals. Relatives provided the following comments, "Ascot Lodge phoned me and gave an update after accompanying (family member) to a hospital visit", "Staff seem to be competent and knowledgeable and quite open and friendly" and "Staff seem to be quite observant and generally care. One relative did report that the staff did not always update them when the GP came out. A person said, "Staff do seem confident and knowledgeable about you."

The menus were on a four weekly cycle and the menu choices reviewed annually. Staff told us people were given a choice of two main meals and two desserts over lunch and that a lighter meal was served at tea time. We saw people were served home baked foods though people and relatives we spoke with told us a lot of frozen vegetables were prepared. We raised this with the registered manager during the inspection and the delivery of fresh produce has since been increased.

We had lunch with people who lived in the home and observed the provision of care and support at lunchtime during the inspection. Lunch was served in the lounge on individual coffee tables; three people ate in the dining room and for people who wished to stay in their own room their meals were served on a tray. The dining room table was laid for lunch though there were no condiments or sauces made available to people.

There were sufficient numbers of staff to assist people with their lunch and evening meal. No one was rushed and staff checked to make sure people had sufficient to eat and drink and to support people who needed assistance with their meal. People were offered a choice of juice and hot drinks before and after meals. A relative had previously been concerned about the frequency of drinks offered to their relative. We checked to make sure people were provided with drinks throughout the day and we observed staff offering these at regular intervals to people in the communal areas and in their own room. Staff told us how drinks were given every hour and we saw these had been recorded. People who were able to express an opinion

did not raise any concerns around the frequency drinks were given.

The menus showed people had a choice of two hot meals at lunch time and a choice of a lighter hot or cold meal in the evening. There was however no menu displayed for people to look at and decide what they would like to eat. Staff told us the chef went round each morning to tell people the menu for the day and to provide an alternative if they did not like what was being cooked. People told us that they were not always informed about the choices available to them. People we spoke with were however happy with the meal served and no one raised a complaint around the lack of choice. We saw alternatives meals being prepared when requested.

Some people required their meals to be pureed as they had difficulty swallowing foods. We saw that the components of the meal were all pureed together. We discussed with the registered manager the use of moulds for the different food to help retain the colour, flavour and improve the overall appearance.

Following the inspection the area manager informed us that a menu board and menus were being provided for people and that a summer and winter menu was being introduced following consultation with people and their relatives. They also informed us that pureed foods were now being served separately to help retain the taste and colour.

The kitchen and preparation area was clean and tidy and all food was stored correctly. People's dietary preferences and specialist diets were known by the chef and staff. These were recorded in people's care files and in the kitchen along with food allergies.

We looked at staff training and support. The records we viewed our observations and talking with people and relatives helped to show the staff had the skills and knowledge to care for people effectively.

A training programme was in place and staff training included food hygiene, infection control, moving and handling, first aid, fire safety, safeguarding, dementia, health and safety, end of life care and mental capacity. Staff told us their training was current and records seen confirmed this. New staff were given an induction which included shadow shifts (working alongside an experienced colleague). A new member of staff told us their induction had been thorough and staff inductions were recorded.

The registered manager was aware of the need to enrol staff on the Care Certificate if they did not hold any formal qualifications in care. The Care Certificate is 'an identified set of standards that health and social care workers adhere to in their daily working life'. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within twelve weeks of starting. Formal training in NVQ (National Vocational Qualifications) or Diploma in Care had been obtained by all care staff as part of their learning and development.

Staff said they received supervision and an annual appraisal and we saw dates of meetings held. Staff told us they received good support from the management team.

Staff effectively monitored people's health and wellbeing and gained advice from relevant external health care professionals. People's care files included evidence of input by a full range of health care professionals. If people had specific medical needs we saw these were well documented and followed through. For example, advice had been sought regarding treatment of pressure ulcers and from the swallowing and language therapy team (SALT) for poor swallowing, eating and drinking. We also saw a record of visits by GPs, dieticians and a community mental health nurse. Staff implemented treatment plans and carried out health checks, for example, recording weights, diabetic monitoring and blood pressure checks.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Deprivation of Liberty Safeguards (DoLS) had been submitted to the local authority for people living at the home. The registered manager was aware that if authorised we need to be informed in accordance with our regulations. The registered manager was knowledgeable regarding the DoLS and had a good awareness of the principles of the MCA including the mental capacity assessment.

Mental capacity assessment had been carried out for people who lacked capacity to consent to their care and we could see that families had been involved in any discussions and agreements regarding care. Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw this followed good practice in line with the MCA Code of Practice. We saw best interest meetings had been held involving relevant health professionals, staff and family member around final wishes and end of life care. A plan of care was in place to support this.

Staff sought people's permission before providing care. Before providing support, we heard staff explaining what they were going to do in a way the person understood.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) plans were in place for some people. These were in accordance with the MCA and had been coordinated by the person's GP.

Good

Is the service caring?

Our findings

People who were living at the home told us the staff were caring, kind and polite at all times and that they listened to them. They told us staff were introduced to them and that they always knocked on their bedroom door before entering. People's comments included, "I decide what I want to eat and what time to go to bed, the staff do listen to me which I like. I like to stay in my room and the staff know that", "Adore the staff", "They ask me what nightdress I want to wear today", "The staff are brilliant, all pals here and on first names", "The manager will pop head around and ask if you want a cup of tea", "Great, get on with every one of the staff", "Can't imagine much better than this, they seem so caring", "When they have time, they (staff) will listen to you", "They (staff) do their best to sit and chat with you" and "Couldn't fault any member of staff."

Relatives told us they thought the staff were caring. Their comments included, Overall they (staff) are approachable given my concerns", "The staff are respectful and caring", "When they see me coming, they make me a cup of tea, they are really friendly."

Over the course of the inspection we saw that staff treated people with kindness, genuine warmth and compassion. We spoke with staff about a number of people living at the home and they were able to provide details of people's health and social care needs and preferences. We saw staff interacting with people in a manner which demonstrated that they understood them and knew how best to support them, for example, when in pain or in need of personal care. Staff took time to explain to people how they were going to assist them and care was given in a calm and reassuring way. Staff took time to listen and make sure people were comfortable before attending to someone else. There was a relaxed atmosphere throughout the day.

Over lunch staff did not rush people with their meals, they offered encouragement and at a pace which suited the individual. We saw there were two staff members present in the dining room to assist people with their lunch. The staff however stood over people in the dining room rather than sitting down next to them which would have made it a more pleasant experience for people. We saw the staff sitting down next to people in the lounge to assist them with their meals. Some people were provided with a tabard to wear during lunch so as to prevent food from spilling on their clothes. Staff did not always seek permission before placing the tabard over people's clothing prior though we observed staff removing the tabards promptly after lunch and checking to ensure people's clothing was clean to promote people's dignity.

We saw staff supporting people to move to the dining room for lunch. Staff encouraged people to mobolise independently and offered the right level of support to ensure their safety and comfort.

Care staff were assigned the role of key worker which enabled them to help oversee social support for a small number of people living in the home. Staff told us they enjoyed this role and records seen provided a detailed over view of the person's social care each month.

From the care records we looked at we could see that staff routinely communicated with people living at the home or their families in relation to care needs. Care files showed that people and their relatives were

involved in the care needs assessment and plan of care.

Friends and relatives were free to visit the home at any time. Relatives we spoke with told us there were no restrictions and some relatives told us that they visited in the evenings and this was never a problem. We saw staff providing visitors with a warm welcome and offering refreshments.

There was information about the home for people and their relatives to view. For example, fire evacuation procedures, complaints procedure, an activities planner and relative questionnaires. For people who had no family or friends to represent them, local advocacy service details were available. An advocate was visiting during our inspection to provide a person with support.

Good

Is the service responsive?

Our findings

We asked people how their care was managed to meet their personal preferences and needs. People told us that they were satisfied with the care they received and that for the majority of the time staff responded to their needs in a timely fashion. People said, "They know what I like and know where I want to sit" and "I like to stay in my room and get up at a certain time, the staff make sure this happens for me." People told us they had a call button to ring for assistance and that staff answered as soon as possible. One person said, "I just shout if I need help and they come pretty quickly." Whilst another person said, "I have my bell in the drawer."

A number of the people we spoke with knew they had a plan of care in place to support their care needs. A person told us about their care and the treatment they were receiving for an on-going medical condition and how staff monitored their condition.

Relatives confirmed that staff had discussed their family member's care and support with them. Comments from relatives included, "A care plan was set up from the beginning when (family member) came here" and "Yes we had input into their care plan, so much so (family member) has now put on weight." Another relative told us their family member's care needs were catered for however they felt dental hygiene could be improved. We brought this to the attention of the registered manager to action.

We asked people and their relatives to share their views about the home's social activities. The feedback we received was there needed to be more varied social programme for people to join in with as the home seemed quiet and 'not a lot going on'. One person told us they that the staff always asked them if they would like to join in but they did not wish to be involved. Relatives said, "There is nothing much to do here", "Yes, safe here (referring to their family member feeling safe) but needs more stimulation."

A barbecue for people and relatives to attend had recently been arranged. This was held in the garden area and staff served food to people outside and for those people who could not leave their rooms, fresh cooked food was brought to each person. People told us how much they enjoyed the barbecue. One person said, "The barbecue food was lovely, if there were more events like this I might be more tempted to come out."

We asked about activities in the home and how these were organised. The registered manager told us there was no activities organiser at the home. The social activities were staff led and arranged mainly in the afternoons for people on a 'one to one' basis.

Whilst there was a scheduled poster of activities on the noticeboard which centred around knitting, chair exercise and balloon games, no group activities were observed during the inspection. We saw a member of staff playing dominoes with one person and painting with another. A number of people sat in the lounge whilst other people preferred to stay in their room and watch television. The television remained on in the lounge on both days and two people were not sat facing the television so they were unable to see it. Three relatives mentioned a balloon ball activity which used to be held, along with a musical instrument event where people could try out different instruments and hear the sounds they all make. There were some

books for people to read, including some historic picture books, which were used to stimulate memories. The overall impression however was one of quiet and although there were some activities planned and agreed for people living in the home there needs to be consideration to expanding this to provide people with a more frequent varied programme of stimulating events.

Following the inspection the area manager told us that a new activities calendar was being put in place for September to December 2016 in consultation with people and their families.

People' rooms had call bells fixed to the wall and a call button given to each person to ring for assistance. For a person who told us their call bell was kept in their drawer we observed this to be the case with the call bell within reach. We did see that two people were unable to reach their call bell; this was rectified by the staff immediately. When people called for assistance staff responded promptly.

Records were in place to record personal care tasks and these were up to date. Information held included fluids and diet taken, a change of position to promote healthy skin, continence care and a mattress check. There was a correlation between these records and people's plan of care.

We reviewed the care records of three people living at the home. The care plans we saw were well developed and provided sufficient information for individualised care. Care documents were reviewed monthly or more frequently to ensure accuracy of the information held and to reflect any change in care or treatment. Care records included information about people's preferences and routines which staff told us helped them to develop their key worker role. Staff we spoke with said they had access to the care plans and the information gave a good over view of people's care and how they wished this to be delivered. We saw care plans for areas such as mobility, eating and drinking, sleep, medication, personal hygiene and communication. Our discussions with staff confirmed their knowledge about people's care provision and we saw care being given in accordance with people's plan of care.

For people who were not able to communicate we saw how staff responded quickly to people's non-verbal signs; this showed a good awareness and understanding of how people expressed themselves. People who were nursed in bed appeared comfortable and had their position changed at different times to ensure their comfort and to lessen the risks of their skin becoming sore.

Pressure ulcer care was recorded and assessments and treatment plans were up to date and in accordance with the current treatment plan for the affected site. Visiting health professionals confirmed that staff followed the treatment plan and contacted them for advice at the appropriate time.

The complaints policy and procedure was displayed on the noticeboard in the entrance. People we spoke with were not aware of the procedure but told us they would speak to the registered manager if they had a problem. Relatives we spoke with told us they knew the home had a complaints procedure and they would speak up if they had a concern. Their comments included, "I would go direct to the manager or regional manager if I had an issue" and "I would talk to a staff member, would tell it like it is."

During our inspection a relative raised some concerns around laundry care. This was raised with the registered manager to investigate and respond using the service's complaints procedure. Following the inspection we were notified of the actions taken to minimise any re-occurrence.

Feedback was sought from people living at the home and their relatives regarding how the service operated. The satisfaction surveys reported favourably in a number of areas though some comments were made around improving the meals. The area manager said this would be addressed.

Good

Is the service well-led?

Our findings

We asked people and relatives about the management of the home. On the whole the response was positive and that when areas of concerns were mentioned the management and staff responded positively to improve the service. People in the home said the management and staff were easy to speak with and approachable. A person told us, "Yes, I can speak to (manager); (manager) usually pops out to have a coffee with me. The manager is very approachable."

We observed that the ratings from the previous inspection, along with the report were displayed in an accessible area for relatives and visitors to access.

We spent time with the area manager and the registered manager to discuss how the service was operating. We also enquired how staff assured the quality of the service to monitor performance and drive forward improvement. We saw a series of audits (checks) on different aspects of the service. This included, care documents, infection control (including hand hygiene checks), disposal of sharps, equipment and premises, health and safety, maintenance and medicines. These audits were current and required actions had been acted on promptly. Medicine audits were completed weekly and on a monthly basis. We discussed with the registered manager ways of improving the content of the medicine audit as the current audit lacked detail about the medicines which had been checked. The registered manager said this would be actioned to help improve the medicine auditing process.

Staff were aware of the concept of whistleblowing and said they had confidence that if they spoke up with their concern would be listened to and acted on. They told us their views were listened to and there was an open and transparent culture.

We saw that staff meetings took place. Staff told us they could share their views at the meetings and felt involved and supported in their job role. They said communication was good and that an open and transparent culture was promoted within the home. Where people or relatives had raised issues with the service these were discussed with the staff so that lessons could be learnt to improve practice. Staff had also been given staff questionnaires to complete so that they were able to make suggestions and share their views.

We discussed the incident reporting system with the area manager. They advised us that any untoward incident was reviewed and incidents would be analysed to check for any emerging themes and patterns. For example, if a person had repeated falls.

As part of monitoring infection control, an external infection audit by a local community health team had been completed in December 2015 and the home achieved 91.4% in infection control standards. Actions needed following the audit had been completed. This month an Environmental Health Officer visited the home and awarded the home five stars for food, (five stars being very good) based on how hygienic and well-managed food preparation areas were on the premises.

Various approaches were in place to seek feedback about the service. This included meetings and also satisfaction questionnaires. A comments book was available in the main hall for people to make comments about the service. We saw minutes of resident and relative meetings and also satisfaction surveys were last sent out this month. To encourage feedback the service had purchased small notepads and these were going to be placed in people's rooms so that people and their relatives could write comments or make suggestions to help the staff improve the overall service. The provision of internet access has also been agreed for the home so that people could access internet services.

During the inspection we spoke with the registered manager around improving social activities, the laundry and reviewing menu choices. The area manager was quick to respond and address the points raised to improve the overall service. This included extended domestic hours to provide two hours laundry cover each day, the provision of menus, a more stimulating programme of social activities and enrolling a staff member on a an activities course. This showed a commitment to moving the service forward.

Plans to improve the environment include laying non slip flooring in the main hall and communal areas. This work was going to take place later this month. The area manager told us that plans to improve the garden included the provision of a summer house.

We discussed with the registered manager their responsibility to notify us of incidents that affected people's safety and wellbeing. We discussed an incident that had not been reported to us however the registered manager submitted the required notification immediately after the inspection. Other notifications had been submitted to us in a timely manner.