H Dhunnoo

Waterfall 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 25 February 2016. The inspection was unannounced. At our last inspection on the 25 June 2014 the service met the regulations that were inspected.

Waterfall House provides residential accommodation for up to 18 adults with continuing mental health problems. On the day of the inspection there were 12 people using the service. The home had two floors with communal living areas situated on the ground floor and bedrooms situated on the ground and first floor. A stair lift was available for those people unable to climb the stairs due to physical or cognitive disability.

The service had a registered manager 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 that we spoke with were positive about the service they received and about the staff that supported them. People told us they felt safe within the home. We saw positive and friendly interactions between staff and people. People were treated with dignity and respect.

Procedures relating to safeguarding people from harm were in place. Staff received regular training in this area. The registered manager and staff understood how to protect people from abuse and knew and understood what to do and who to report to if people were at risk of harm.

The manager and staff had sound knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, one newer member of staff did show lack of understanding in these areas but was due to attend training. One DoLS application had been submitted to the local authority and the service was awaiting a response from the DoLS team. Mostly all people living at the service had capacity and were supported to maintain an independent life where possible. People had been given a set of keys to the home and were able to leave the home as and when they wished.

Care plans were detailed and contained relevant information about the person, their needs and preferences. However, care plans lacked a person centred approach and provided little information on people's

background and history. Consent to care was sought from the person using the service and care plans recorded people's involvement when reviewing and updating the care plans. Risk assessments within the care plan identified the risks to people and how these could be prevented and although staff and the registered manager knew people very well and were aware of all potential risks some of these had not been recorded as part of the care planning process.

The registered manager ensured safe and robust recruitment processes were in place to protect people from the risk of harm. Staff received appropriate induction and mandatory training and demonstrated the knowledge and skills to carry out their role effectively, however some gaps had been identified within the training schedule especially in the subject areas of MCA and DoLS and equality and diversity. Staff received regular supervisions and support and were given the opportunity to discuss their strengths, performance and training needs. Annual appraisals had also been completed for all staff files that we looked at.

Staffing levels were determined based on level of need assessments which had been completed for each person living at the service. The registered manager also formed part of the staff team during the day and was observed to be 'hands on' and involved in the provision of care and support.

People were supported to have their medicines safely and on time. The registered manager and senior care staff completed regular weekly audits to ensure safe management of medicines, however, these were not recorded. We spoke to the registered manager about this who assured us that they will begin to record all weekly and monthly audits as part of a formal process. Staff had completed training on medicines administration and the home had a clear policy on administration of medicine which was accessible to all staff.

People were supported to ensure they ate and drank well. Menus were set with the people using the service and were discussed at regular resident meetings. Some people prepared their own meals and were supported to ensure that their cultural and dietary requirements were adhered to.

People had access to a full range of healthcare services including the GP, district nurses, opticians and chiropodists. Some people were able to make their own appointments and attend those appointments independently.

The service had a complaints procedure and a grumbles book. All complaints and grumbles were recorded as per the policy. Residents meetings were also used as a forum to address any issues or concerns people living at the service had.

An accident/incident folder was in place which recorded all incidents that had occurred within the home and the action that the service had taken. It was positive to note that there had been no recording of any accidents since October 2014.

The management team including the nominated individual were accessible and approachable. People and their relatives knew who the manager and nominated individual was and were able to speak with them if they had any concerns or issues. Staff also confirmed that the managers of the service were approachable and very supportive.

The registered manager told us that they carried out regular audits of care plans, medication, health and safety and the environment. During the inspection no major issues or concerns were identified in any of the above areas, however, other than a reminder noted in the communal diary, these audits were not formally recorded. This included lack of information on issues, if any, that had been found and how these had been

addressed. We spoke to the registered manager about this who told us that they would immediately begin to implement this formal process of recording.

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. Procedures were in place to protect people from abuse. Staff knew how to identify abuse that might occur in the service and knew the correct procedures to follow if they suspected abuse had taken place.

The risks to people who use the service were identified and staff were knowledgeable about each individuals associated risks and how to manage these. However, some of the less obvious risks, which staff were aware of, had not been documented as part of the care planning process.

People were supported to have their medicines safely.

There was sufficient staff to ensure people's needs were met.

Is the service effective?

Good

The service was effective. Staff were supported through training and supervision to develop their understanding and skills to meet people's needs. However, some gaps were identified in the provision of formal training especially in particular subject areas.

The service was meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were supported and enable to make their own choices and decisions.

People were supported to eat a healthy diet and were able to choose what they wanted to eat.

People had access to health and social care professionals where required and were involved in decisions about their health and the support they required.

Is the service caring?

Good

The service was caring. People told us they were treated with dignity and respect. People also told us that staff members maintained their privacy at all times and we observed this happening as part of our inspection

Staff were aware of peoples individual needs, behaviour patterns and how they were to meet those needs and support them appropriately.

People were enabled and encouraged to be as independent as possible and were supported to make informed decisions about their care and support.

Is the service responsive?

Good

The service was responsive. People were involved in decisions about their care. Staff understood how to respond to their changing needs.

People and their relatives knew how to make a complaint. The service had received very few complaints since 2014 and made sure that people's issues or concerns were addressed as part of the regular residents meeting process.

People were encouraged to have full and active lives and be part of the community.

Is the service well-led?

Good

The service was well-led. There was confidence in how the home was managed.

There was a clear management structure in place and staff felt supported in their role by the registered manager and the nominated individual.

The registered manager and senior care staff monitored the quality of the service on a regular basis but did not record these as part of a formal process. Although as part of this inspection no serious issues had been identified there was little information available in terms of when audits had taken place, if any issues had been identified and what action had been taken to resolve and improve services.

Annual resident, relative and stakeholder surveys were carried out with the most recent completed in September 2015.

Waterfall 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.

This inspection took place on 25 February 2016 and was unannounced.

The inspection team comprised of one inspector and a specialist adviser who was a social worker who had working knowledge of mental health.

Before the inspection the provider had completed a Provider Information Return (PIR). This is a form that askes the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we had about the provider including notifications and incidents affecting the service and well-being of people using the service. We also contacted Healthwatch Enfield and a number of local authority commissioning teams for their views about the home.

On the day of the inspection we spoke with six people who used the service, one relative, the registered manager, nominated individual and a further four staff members. We spent time observing care and support in communal areas. We also looked at a sample of four care plans of people who used the service and four staff records. Other documents we looked at included risk assessments, medicine records, resident and staff meeting minutes as well as health and safety documents.

Good

Our findings

People that we spoke with told us that they felt safe at the home. One person told us when asked if they felt safe, "Yes, I am safe at the home." Another person told us, "I do feel safe here." One relative told us, "I am very happy with the care the home provides and I am re-assured that my relative is very safe there."

We observed staff engaging positively with people living at the home. The atmosphere was relaxed and interactions between staff and people were person centred and ensured people were safe and that they were enabled to maintain their independence.

Systems and processes were in place to protect people from the risk of abuse and avoidable harm. The service had a safeguarding policy in place which had recently been reviewed. The policy was detailed and provided information which included details of what abuse is, reference to latest legislative changes, spotting signs of abuse and a number of case studies to aid staff in identifying various forms of abuse and situations where abuse could take place.

Records showed that staff had completed training on safeguarding people. Staff that we spoke with were aware of the policy on safeguarding and knew what action to take if they had any concerns about people. One staff member told us, "Everyone should be safe from abuse" and another staff member told us that, "If I had any concerns I would report to the manager." Staff were also aware of whistleblowing and what this meant. Staff were able to tell us who to contact if they needed to. A whistleblowing policy was available which provided clear guidance and listed who staff could contact if they needed to report a concern. This included contact details for the local authority and the CQC.

The registered manager and staff members were aware of the risks associated with people's care and how to manage and minimise risk. The service had overall risk assessments that covered the workplace environment and slips, trips and falls. Care plans that we looked at listed individual peoples identified risks which included manual handling, the refusal to have window restrictors on first floor bedroom window and where a person did not want to be disturbed or checked upon during the night. However, there were some risks which the registered manager and staff members were aware of but these had not been documented as part of the care planning process. This included risks associated with infection control or weight loss. As part of our feedback we highlighted this to the registered manager who told us that they would make sure these assessments were completed and added to the care plan.

Care plans identified warning signs that might indicate that the person's behaviour could become

challenging and how staff could mitigate and intervene to support the person so that their safety and well-being was maintained. The care plan identified the needs and problems of the person, the objectives of care required and the action to be taken. The registered manager and staff members were able to explain in detail how they responded to behaviours identified in people's care plans.

Most people living at the service were supported by staff to maintain their independence. We observed that there was sufficient staff throughout the day with one waking night staff on duty at night. Rotas for the last three weeks showed that two staff plus the manager were allocated to the morning shift and the same for the afternoon/evening shift. The registered manager told us that staffing levels were structured around the needs of the people living at the service. Staffing levels could be and were adjusted when people's needs changed which may have had an impact on other people living at the home. One person we spoke with told us, "There is always enough staff."
A staff member also told us, "There is always enough staff and the manager is also there to help."

We looked at four staff files and saw that there was a robust process in place for recruiting staff that ensure that all relevant checks were carried out before someone was employed. These included appropriate written references and proof of identity. Criminal record checks were carried out to confirm newly appointed staff were suitable to work with people. The service also had systems in place to ensure people were eligible to work in the UK and that this was reviewed when visas were due to expire. The service worked very closely with local colleges, where foreign students were obtaining a qualification to ensure they were working in line with their student visa requirements. Colleges provided the service term timetables so as to allow the service to ensure that students did not breach their visa requirement and only worked the number of hours allowed as per their visa.

The service did not use any external agency staff to cover staff sickness or annual leave. The registered manager told us that their current staff team were very supportive and all shifts were covered by the team whether it be at short notice to cover staff sickness or when staff were on planned annual leave.

The home had a clear medicine administration policy which staff had access to. People's medicines were recorded on Medicines Administration Record (MAR) sheets and the service used a blister pack system provided by the local pharmacy. We observed medicines being administered and saw that two staff members were present to administer medicines. Both staff checked each record and ensured that the correct medicines were administered to the correct person at the correct time. Both staff members also signed the MAR sheet. We noted that people's medicines were given on time and there were no omissions in recording of administration.

We found medicines to be stored securely and appropriately. A medicine fridge was also available but was not being used at the time of the inspection. Temperature checks were carried out for both the medicines cupboard and fridge and these were recorded to ensure that medicines were stored at the correct temperature.

Each person had a medicine profile attached to their MAR sheet. This detailed information about the person, their medical profile, their photo and any known allergies that the person may have. The service also held information fact sheets about each and every medicines people had been prescribed which included information about the medicine, what they were prescribed for and any possible side effects.

Homely remedies were stored in the locked cupboard along with all other medicines kept at the home. Records were kept of when people had received homely remedies and why they had been given a homely remedy. Controlled medicines were also stored in the same locked cupboard. At the time of the inspection

the service had only one controlled medicine. We checked stock levels of this medicine and it corresponded with what had been recorded in the controlled drugs record book.

Some people had injections as part of their medicine regime. This service was provided by the district nurse. The service ensured that the person received their injection when it was due and also made records in a diary of when their next one was due. One person had been prescribed eye drops which they administered themselves. This had been recorded appropriately on their MAR chart. Another person received medicines that were crushed as they would refuse medicines that were given in whole tablet form. The service had recorded this as part of the care planning process and included an authorisation from the GP as well as a record that this method of administration had been discussed with the person and that they were in agreement of this.

Staff had undertaken training to administer medicines and had their competency checked by the registered manager to ensure they continued to do this safely. Also as part of the MAR folder, there was a list of all prescribing and administering staff members and their signatures so that administering officers could be identified when audits and checks were completed.

An accident/incident folder was in place which recorded all incidents that had occurred within the home. Information recorded included details of the incident, where it happened and the action that the service had taken. It was positive to note that there had been no recording of any accidents since October 2014.

We looked at maintenance records for the home which included yearly, monthly and weekly fire checks and weekly smoke alarm checks. These were completed to ensure staff and people knew what to do in an event of a fire. In addition to this each person's bedroom had a poster on their wall outlining fire evacuation instructions and procedures for people to follow. The service also had a grab bag kept in the main office which included resident information sheets, resident list with the name of their allocated key worker, evacuation guidelines for each individual person and emergency contact numbers for all managers, staff, people living at the home and their relatives. This collective information helped ensure that people's needs were known to staff and to emergency service so that they could be supported and evacuated from the building in the correct way. We also looked at regular, on-going maintenance records including gas, electrical, emergency light, water temperature and food temperature checks.

The home was clean and well maintained. An infection control policy was in place. The registered manager and staff demonstrated a good understanding on how to maintain cleanliness and infection control within the home. Correct hand washing technique posters were visible around the home. All chemical cleaning products were kept in a locked cupboard and a laundry protocol for soiled laundry was on display in the laundry area. We also saw a cleaning schedule for the home and we also saw records of specific cleaning that took place around the home including carpet cleaning and deep-cleans of particular areas.

Good

Our findings

People were supported by staff that were appropriately trained and able to meet their needs. Staff that we spoke with told us that they were supported through regular supervisions and annual appraisals. Supervisions took place with the registered manager and senior care worker. One staff member told us that as part of their supervision they discussed "issues and weaknesses as well as training and development." Supervisions took place every two months which was as per the service's supervision policy. They also told us that they received regular training and that the management was very good at identifying training and development needs for them. This was confirmed by the records that we looked at. One staff member told us, "The manager is very supportive; I feel I am challenged within my role and I feel like I am excelling in my career."

We saw that staff had received an induction prior to them commencing work to ensure they understood people's needs and how to support them. This included getting to know people and understanding local policy and procedures. Staff received training in mandatory subjects which included food hygiene, health and safety, first aid, administration of medicines and safeguarding. Staff also received specialist training in areas such as dementia, diet and nutrition, Mental Capacity Act 2005 and DoLS. However, not all staff had received training in certain areas including MCA and DoLS and equality and diversity although, when we spoke with staff they were able to demonstrate a good knowledge base in these areas. We highlighted this to the manager who told us that they would organise sessions in these areas as soon as possible.

The service had also made arrangements to provide induction training as per the newly introduced Care Certificate. The registered manager showed us the training booklet that all newly appointed staff would be required to follow and complete.

The registered manager and staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 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.

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 Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the

principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made one application to the local DoLS team and was awaiting a decision on the application.

Staff that we spoke with demonstrated a good understanding of the MCA and DoLS. One staff member told us that, "The MCA is applied where someone lacks the capacity to think on their own. A DoLS application is required for protection of the person and the staff providing support." Another staff member explained to us the principles of the MCA and why a DoLS application is required by giving us an example of one person living at the home that expresses the wish to leave the home and would wait at the door. This person is unable to leave the home on their own and would require support therefore in this situation a DoLS would apply.

Most people living at the home had capacity to make their own decisions about the care and support they required. People had been given keys to the home and could leave the home and access the community as and when they chose.

The registered manager and staff understood the importance of obtaining consent. Care plans that we looked at were signed by the either the people using the service or their relatives.

During the inspection we observed staff members seeking consent from people in respect to day to day activities. One care worker asked two male people whether they wanted to have a shave. One person agreed and the other refused. One person wanted to change the music CD that was playing in the background. Before the care worker changed the music they asked the person who had chosen the music that was playing if they could change to which the person agreed and stated that, "I don't mind."

People were involved with the setting of weekly menus for the home. We saw resident meeting minutes that meals and choice of meals were discussed on a bi-monthly basis. Meals were mainly prepared by staff but some people living at the service enjoyed supporting the staff with the preparation of the meals. One person peeled all the vegetables required for the day. This was a daily routine that they followed. The same person also cooked their own meal as they were a vegetarian and enjoyed cooking their own meal which on occasions other people living at the home shared with them. Another person was responsible for setting the tables before a meal and also clearing up the dining and kitchen area after each and every mealtime.

Lunch and evening menus were displayed on the wall for the week and even though the meal choices were made by the people living at the home, people could still change their mind and request for an alternative on the day. Any change in meals would then be recorded in a specific book which was kept for this purpose so that the service could evidence where people had requested a change and what alternative was offered and accepted.

People spoke positively about the meals that they ate. One person told us, "The food is good and if I don't want what's on the menu o can choose something else." Another person told us, "I get asked and given a choice and the food is good." We observed that people had access to food, snacks and drinks at any time that they wanted. One person we spoke with told us, "I get a coffee and two slices of toast at 8pm as a snack." People could choose whether they wanted to eat together in the communal dining area or somewhere else which was comfortable for them.

We observed lunchtime as part of the inspection. Tables were laid with a variety of condiments available for people. Staff and the registered manager were noted to be available throughout the duration of lunch and were available for support where required. Food that was served looked appetising and people ate well and

even asked for second servings.

The kitchen was clean and we noted that sufficient quantities of food were available. Further, we checked a sample of food stored in the kitchen and saw that they were all within their expiry date. Food that had been opened was appropriately labelled with the date they were opened. The kitchen had designated food preparation areas for preparation of meat and vegetables and used colour coded equipment for this purpose. Fridge and freezer temperatures were recorded on a daily basis and food temperatures when cooked and served were also checked and recorded.

Each person had access to health professionals where required. Records showed people received care and treatment from health care professionals such as their GP, chiropodist, optician, district nurses and psychiatrists where required. All visits were recorded within the care plan. Most people living at the home were enabled to make their own appointments and were able to attend those appointments independently. One person told us, "I am well looked after and I make my own appointments with the GP and I go to the GP myself."

During the inspection, with the permission of people living at the home, we visited five people's bedrooms and we also looked into a vacant room. People's names were seen on the door of the room identifying whose room it was. Rooms were not as personalised as they could be. We discussed this with the registered manager who explained to us that people chose to decorate their rooms in the way they wanted. We did see some rooms that had televisions and radios as per the wish of the person living at the home.

Good

Our findings

We observed people being treated with dignity and respect. People whom we spoke with also confirmed that staff were caring and respectful. One person told us, "This is my best place, my home" and "the staff here never make us worry or harm us, they do wonders for us." Another person told us, "We are well looked after, it's a good home here." One relative we spoke with told us, "I am made to feel very welcome when I visit my relative. Over the years I have known the staff to be very caring."

People were supported to maintain relationships with friends and family and were supported to access the community when people wanted to. One person told us, "I go to the betting shop, that's my activity, I have friends there." Relatives and visitors were able to visit at any time.

People were given a key to the home and were able to leave and enter the home as they so wished. One person told us, "I can go out whenever I want" and another person told us, "I go and buy a newspaper every day." People told us that staff always gained consent and always knocked on their bedroom doors before entering. We observed staff using the term of address favoured by the person.

People were involved in decisions about their care. The service had a key worker system in place and people we spoke with knew who their key worker was. A key worker is a staff member who monitors the support and progress needs of a person they have been assigned to support. Staff knew how to respond to people's needs in a way that promoted their individual preferences and choices regarding their care. Care plans contained a variety of information about individual people including their likes and dislikes and methods on how best to support their emotional and physical needs. However, care plans were more clinical opposed to being person centred. A life history about the person and their background was not available. Although, the service did compile a 'pen picture' about the person, this was seen to be a more of a tick box exercise instead of a live working document which the person could be more involved in creating.

The service held bi-monthly residents meetings where people were given the opportunity to talk about anything that they wanted, express their views and contribute to how the service was run. Topics discussed included menu's, day to day grumbles and any issues or concerns they may have.

We spoke to the registered manager and a staff member about how they would work with lesbian, gay, bisexual and transgender people. The registered manager told us, "Supporting people from the LGBT spectrum would not be a problem." A staff member told us, "I cannot treat someone differently just because they are lesbian or gay. It is their choice and I cannot force my views and opinions on them."

We spent time during the inspection visit in communal areas observing interaction between staff and people who lived at the service. At the beginning of the day the registered managers took the inspection team around the home and introduced us to all the people. Staff were respectful and spoke with people considerately. We observed that after lunch people wanted to watch the one o'clock news. The registered manager offered people a choice of which channel they wanted to watch the news on. The manager also went on to ask them if the volume of the television was at an acceptable level or whether they needed it to be louder.

Throughout the inspection, we observed people were provided with the choice of spending time anywhere in the service including their own rooms and communal areas. People had freedom of movement around the home. We also observed people holding meaningful conversations with each other and had developed positive relationships with each other.

People had access to advocacy services where required. The service had established links with a local organisation which supports and provides activities for people with mental health problems. The registered manager told us they had established good links with this organisation however, people living at the home chose not to attend the activities that were being offered.

Good

Our findings

We looked at four people's care plans and saw that staff responded to people's needs as were identified. Care plans were reviewed every six months or as and when required if any significant changes had taken place. People were involved in planning and reviewing of their care and support needs and where appropriate people had signed their care plan to confirm this. People that we spoke with confirmed that every time their care plan was reviewed they were involved in this process and that their key worker would go through the care plan and they would sign to agree with what was discussed. One person we spoke with told us, "I know my key worker and I have seen my care plan. My keyworker goes through the care plan and I sign my name."

Appropriate arrangements were in place to assess the needs of people prior to admission. The registered manager told us that they normally carry out the pre-admission assessments. They then invite the person and their family to the home for a visit and a trial stay before any agreement is made about long term placements. The registered manager felt this was a very important process to follow to ensure a positive and successful admission.

People received personalised care that was responsive to their individual needs. Staff were aware of how each person wished their care to be provided. Each person was treated as an individual and received care relevant to their specific needs and in line with their assessment of need. People's care plans included information relating to their specific need and provided guidance on how they were to be supported by staff.

There were some people living at the service that could become anxious or distressed. Staff were well aware and demonstrated a good understanding and awareness of how that person was to be supported during this time to ensure the persons safety and well-being was maintained as well as the safety and well-being of the staff members supporting the person. This information was detailed within the care plan but was not presented in a person centred and outcome based way and was found to be quite clinical and task focused.

Although care plans were found to be not very person centred, staff members had a very good understanding of what person centred care was. One staff member told us, "Person centred care is about listening to people's ideas and respecting their ideas. It's about how they want their privacy and dignity protected. It's not about what we want. We cannot force them to do anything, we can only advise." Another staff member told us, "People can choose for themselves. We can only support them or prompt them."

People were supported to engage in a range of activities that reflected their personal interest and supported their emotional well-being. One person told us, "I like playing dominoes." Another person told us, "I always watch the football on TV especially when Chelsea are playing." One person told us, "I do my laundry once a week." During the inspection we observed people engaged in a number of activities including playing dominoes, doing origami, listening to music. Some people were observed to be involved in day to day occupation which included setting tables for mealtimes, clearing up after mealtimes, cleaning the kitchen and preparing vegetables for cooking.

An activities plan was available on the wall which reflected what people wanted to do. The manager told us that during winter the activities were mainly indoor based and during summer outdoor activities were planned. The home also had a variety of books available for people to read if they wanted to. The home provided a daily free newspaper but some people chose to go out and buy their own choice of newspaper. Photos of past activities and outings were displayed on the wall.

Staff understood people's needs with regards to their disabilities, race, religion and gender and supported them in a caring and responsive way. Care records showed that staff supported people to practice their religion and attend community groups that reflected their cultural backgrounds. The home also arranged for weekly visits by the local church to take place so that people who chose to practise their religion could do so within their own home. People also went to the local church to attend church services.

The home had a clear complaints procedure in place. People knew how to make a complaint and knew that their concerns would be dealt with. One person told us, "Mr H (the nominated individual) will sort out if I have any complaints" and another person told us, "I know the manager and they would help us out if I had any complaints." One relative we spoke with told us, "I have no concerns with the care but I know who to speak to if I did and I know it would be dealt with."

A complaints book was kept to log any complaints received. The information recorded details of the complaint, what action the service had taken and how the complaint was resolved. People felt confident about raising issues with staff and had the opportunity to discuss any concerns they had at regular resident meetings. We saw minutes of these meetings which confirmed the discussions that people held with the manager. Staff were also aware of the complaints procedure and knew how to respond to people's concerns and complaints.

Records showed joint working with the local authority and health care professionals involved in people's care. The registered manager told us that they work closely together to make sure that people receive a good standard of care.

Good

Our findings

During the inspection we observed that the home had an open culture that encouraged good practice. People that lived at the home and staff members that we spoke with also confirmed this. One staff member told us, "the registered manager is a very good manager, very understanding." Another staff member told us, "I enjoy working here, the management is very good and supportive. Staff are very happy and we work together as a team." People and their relatives were very positive about the management of the home and thought it was well run. They were complimentary about the registered manager and the nominated individual and felt both were very approachable. Both the registered manager and nominated individual knew the people living at the service very well.

There were records of regular staff meetings that allowed staff to discuss care needs of people living at the service, training needs, feedback from staff and further development of services. Staff also told us that they could approach the manager at any time.

The registered manager and nominated individuals presence was felt and observed around the home. On the day of the inspection we saw the registered manager visible on the floor supporting the staff team in supporting the people living at the home. The nominated individual was also visible around the home speaking with people. One person told us, "I know the manager and the owner. Mr H is very good." Another person told us, "Mr H sometimes spends the night here and keeps a check on us, I feel very safe."

The registered manager told us that they completed regular weekly medicine audits, care plan audits and health and safety and environmental audits. However, these were not recorded. There were some prompts and reminders recorded within the general diary, which is what the registered manager and senior care staff used as a reminder that supervisions and checks were due and although during this inspection we did not identify any significant issues we highlighted the lack of recording as an issue with the manager who told us that they will begin to record all the audits that they carry out.

The registered manager also told us that occasionally people living at the service would check their own medicine to see if what they were being administered was correct but the service did not record this. This was a great and innovative idea and told the registered manager that they should record this as evidence that people were involved in auditing their own medicine and administration of.

The service had a comprehensive range of policies and procedures necessary for the running of the service which included a business continuity plan. This ensured that staff were provided with appropriate guidance

and direction. The registered manager had kept a book to confirm that staff members were reading and understanding some of the key policies in place especially if there had been any updates. Staff members were required to read and sign the book each time this had been completed. We saw that recent entries had been made in the book.

People were involved in providing feedback about the quality of care that they received through regular residents meetings. The service also sent out annual questionnaires to relatives and health care professionals, the last one being sent in September 2015. Feedback received was positive and included comments like, "I am given an update on my relative's health and well-being every time that I visit" and "My relative is safe, secure and well cared for. He is happy there."