Croftwood Care Ltd

Greenacres Residential Care Home

Inspection report

Green Lane
Standish
Wigan
Greater Manchester
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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

The inspection took place on 28 April 2016 and was unannounced.

We last inspected this location on 13 September 2013, when we found the service to be compliant with all the regulations we assessed at that time.

Greenacres is a large purpose built home situated in the village of Standish, which sits on the outskirts of Wigan town centre. It is part of Croftwood care which is owned by Minster Care Group. The home is registered to provide care and support for up to 40 older people. There is a residential unit that can house 28 people and 'Langtree Court' which can accommodate 12 people living with a diagnosis of dementia. At the time of our inspection there were 39 people living at Greenacres. There was one vacancy on the residential unit. Both units have communal lounge and dining areas. Rooms in the residential unit are located upon two floors with a passenger lift for access whilst Langtree court is a purpose built bungalow. Car parking is available at the home.

The service has a registered manager. 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 told us they felt safe living at the home. People had comprehensive risk assessments which were reviewed and updated in a timely way to meet people's changing needs. People and their relatives told us they were well informed and had been involved in the assessments and planning of the care and support received.

The home had suitable safeguarding procedures in place and staff were able to demonstrate that they knew how to safeguard people and were aware of their roles, responsibilities and the alert process. Appropriate employment checks had been conducted before new staff commenced employment in the home, to make sure as far as possible that they were of suitable character to work with vulnerable people.

The home had sufficient numbers of staff deployed which was formally calculated based on people's dependency. We found staff were able to meet people's needs efficiently and all the people spoken with confirmed their needs were met in a timely way.

Staff felt well supported. Staff received an induction, supervision, annual appraisal and sufficient training to promote better outcomes for people.

People were supported in line with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). When people could not make certain decisions for themselves, people's rights were protected and 'best interest' decisions were conducted in partnership with families, professionals and

advocacy services. Staff understood the Deprivation of Liberty Safeguards (DoLS) and recognised that people were not to be restricted unnecessarily.

People were supported to attend health care appointments and received healthcare that supported them to maintain their wellbeing. People were offered a choice of foods and their suggestions were considered when meal planning.

Staff treated people with kindness and respect. People's privacy and dignity was maintained and people told us that staff were respectful of their wishes. People were encouraged to maintain their relationships with friends and family and there were no prescriptive visiting times imposed by the home.

People's independence was encouraged and staff balanced this with providing appropriate care and support. People spoke positively of the staff and valued the relationships that had formed.

People's life plans were reflective of their preferences and needs. Staff also demonstrated a good understanding of the needs and wishes of the people they supported.

People and their relatives knew how to make a complaint. They told us they were confident in the manager and had never had any concerns or raised an issue. People were asked for their input in how the home was run through resident meetings and surveys had recently been sent to people and their relatives to illicit their feedback and drive improvements.

The manager and provider had effective procedures to measure the quality of the care received. It was evident that areas identified had been addressed and there was a clear audit trail of actions implemented.

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.

The service had safeguarding and whistleblowing policies and procedures which staff demonstrated they knew in order to keep people safe.

Risk assessments were comprehensive, reviewed regularly and changed in a timely way to meet people's needs.

The service had arrangements in place for recruiting staff safely and there were enough staff on duty with the right skills, knowledge and experience to meet people's needs.

Processes were in place to ensure people's medicines were managed safely.

Is the service effective?

Good

The service was effective

Staff told us they received training relevant to their role and had regular supervision.

Staff understood the importance of obtaining consent and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good

The service was caring

People were treated with kindness, care and respect by staff who promoted their independence.

People's privacy and dignity was respected and promoted.

People were listened to and were supported to make their own decisions and choices.

Is the service responsive?

Good

The service was responsive

People's choices and preferences were taken into account by staff providing care and support.

People were actively encouraged to maintain their relationships and there was an activities programme to reduce the risk of social isolation.

A complaints procedure was in place and staff knew how to respond to complaints.

Is the service well-led?

Good

The service was well-led

The culture of the service was open and inclusive. The manager was visible to staff, relatives and people who used the service and we received positive feedback about their leadership from people, their relatives and staff.

The provider and registered manager carried out audits and checks to
make sure people were receiving a quality service.

Greenacres Residential Care 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 checked 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 was carried out on 28 April 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Greenacres has two units; a residential unit and Langtree court which is home to people living with dementia. The residential unit provides accommodation for up 28 people and has two floors which are serviced by one lift. There is a communal and quiet lounge on the ground floor and a second quiet lounge on the first floor. Bedrooms are located on both floors. Langtree is a customised bungalow. There is a dining area and lounge. The garden area is accessible from Langtree which all residents on both units are able to access. There were 29 people on the residential unit and 12 people on Langtree at the time of the inspection.

Throughout the day, we observed care and treatment being delivered in people's rooms and communal areas which included communal lounges and dining areas. We also looked at the kitchen, bathrooms and external grounds. We asked people for their views about the services and facilities provided. During our inspection we spoke with the following people:

- Three people living on the residential unit and one person living on 'Langtree court'.
- Five visiting relatives
- Eight members of staff, which included; the registered manager, care team leaders, senior carers and carers.

We looked at documentation including:

• Eight care files and associated documentation
• Six staff records including recruitment, training and supervision.
• Five Medication Administration Records (MAR)
• Audits and quality assurance
• Variety of polices of procedures
• Safety and maintenance certificates

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding and incidents, which the provider had informed us about. A notification is information about important events, which the service is required to send us
by law. We also looked at the Provider Information Return (PIR), which we had requested the registered manager complete prior to conducting the inspection. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

We liaised with external professionals including the local authority and local commissioning teams. No issues of concern were raised by external professionals contacted. We also reviewed previous inspection reports and other information we held about the service.

Good

Is the service safe?

Our findings

Everybody we spoke with living at Greenacres, told us they felt safe living at the home. Relatives told us; "I've had no concerns about [person's] safety since they moved in. It's brought our family nothing but relief." "I have no concerns at all. [Person] is safe and they keep me informed if there is a concern. [Person] has had falls at home which is why they moved in. They risk manage [person] and they've had physiotherapy involved. "

Prior to conducting the inspection, we had received information alleging that there was insufficient staff deployed at night to meet people's needs. We asked the registered manager to show us how the staff rota was devised. We found that staffing levels were determined using a formal method to calculate staffing levels based upon people's level of dependency. We looked at people's dependency and saw that the tool was being applied accurately to assess people's level of need. The dependency tool calculated the care hours needed to effectively meet people's needs.

We looked at the care hours calculated as being required for November 2015, February and April 2016 and cross referenced this information with the staff rota for these months. We found that there was sufficient staff rota'd to work these months and the care hours provided exceeded the dependency calculation. We asked people, their relatives and staff whether there were sufficient numbers of staff deployed to meet people's needs. Without exception, all the staff told us that they felt there was enough staff to meet people's needs timely. One person told us; "they do their best but they would benefit from more staff." We asked them if they had ever had to wait for their needs to be met day or night and they told us; "No, I've never had to wait for things. They come with the bed pans when I buzz and I've never had an accident waiting." One relative told us that on some occasions they'd noticed staff to be busier and thought they'd benefit from an extra staff member but confirmed they had not observed staff being unable to meet people's needs.

On Langtree court, we observed there were twelve people who used the service and three members of staff on duty; a team leader, a carer and a domestic. Staff confirmed this was sufficient to meet people's needs. Staff told us if a person was unwell and required more help, a member of staff from the residential unit would be asked to assist. We were told if the situation persisted an extra member of staff would be rota'd for the length of time needed. All the staff we spoke with on this unit felt supported and were confident that staffing levels were always satisfactory to meet the needs of the people who used the service. Despite the information received prior to undertaking the inspection, we concluded that there were sufficient numbers of staff deployed to meet people's needs and to keep them safe.

We looked at the procedure for managing medicines within the home. Prior to conducting our inspection, we had received four recent medication error notifications which had been investigated by the local authority. We looked at one of the errors which involved a new admission to the home. The person had brought their own medication which had run out. The home had ordered the medication but it had not been received. The staff on duty had rung the out of hours GP when this had occurred and obtained a prescription but several chemists they tried did not stock the medication and it was ordered for the following day. We saw that the person had been observed through the night to assess for any detrimental impact. We saw the

other incidents had occurred as a result of human error. The manager had investigated the incidents and discussed with one person living at the home a change in medication time to synchronise with their other medications which had been implemented. All staff involved in the incidents had been communicated with and we could see actions taken to prevent further re-occurrence were documented.

We saw that medication was administered by care team leaders (CTL's). We checked the training matrix and saw the CTL's had obtained a level 2 in medication training. We spoke to three CTL's who told us that the manager also conducted competency assessments and observed them dispensing medication.

We found medicines were managed safely. We observed part of a medicines round and saw the nurse took their time with people and asked people how they wanted to take their medication. The nurse was patient, knelt down when speaking to people and gave them sufficient time and support to take their medicines. They ensured medicines had been swallowed before signing the medicines administration record (MAR) chart. The April MAR charts looked at were all signed and completed with no omissions.

Medicines were stored in locked trolleys within locked clinical rooms. Fridge items were kept in medicine fridges and the temperatures were checked daily. Items stored in fridges, such as eye drops, had been dated when they had been opened to make sure staff knew how long they could be used for. Medicine audits took place weekly and were actions from audits had been identified we could determine what action had been taken by whom and when to address the issue. For example, it had been identified that staff were inconsistently managing a person's PRN on Langtree. PRN is when medicines are taken as and when required. This had been addressed by the manager in a team meeting and the expectation identified.

On the day of our inspection, we looked at the care and support documentation for eight people. We did this to establish if people were receiving the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. We saw people's risk assessments were comprehensive and actions taken were clearly identified to mitigate the risk of future re-occurrence. For example; we saw a person that had had a fall. A falls risk assessment tool (FRAT) had been completed. The information detailed what action had been taken following the incident. We ascertained that the person had been placed on an observation chart following the fall and the GP had been contacted. We saw the person was under the care of the falls team and the GP had arranged tests to investigate the cause. The results obtained were documented in the life plan so it was easy to follow what had been explored. A pressure mat transmitter had been installed next to the person's bed. This would raise an alarm when the person got out of bed and alert staff so they could respond and support the person when mobilising which would help to reduce the risk of the person having a further fall.

Risk assessments included people's health needs. For example; We saw a person that was diabetic and the assessment included how the diabetes was controlled and the frequency of monitoring. People's allergies were easy to identify and risks of malnutrition were covered. We saw that detailed guidance of how to manage risks were outlined and reviewed. Staff confirmed that they had read the risk assessments and the associated guidance. This showed that possible risks to people were identified and managed appropriately.

We saw that people did not have individual personal emergency evacuation plans (PEEP's) in their care files. We asked the manager who showed us that they were currently being undertaken and the manager identified that the plans would be completed by the end of the month. This demonstrated that the manager had already commenced addressing this requirement and put plans in place to meet this deficit.

There was an appropriate safeguarding policy and procedure in place. Staff were able to describe the service process and the local authority protocols. All the staff spoken with were able to describe types of

abuse and the procedure to follow. A staff member told us; "Abuse to people could be; physical, emotional, financial, neglect. If I suspected abuse, I would report to the manager, area manager and the duty team at the local authority."

We asked staff about whistleblowing. All of the staff we spoke with told us they would not hesitate to use the policy and identified internal reporting protocols and referred to external agencies they could contact. For example, CQC if they did not feel that the area manager or head office were responding to their concerns.

People were protected against the risks of abuse because the service had a robust recruitment procedure in place. Appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. During the inspection, we looked at six staff personnel files. Each file contained a job description, application form, interview questions, and a minimum of two references and evidence of a DBS (Disclosure Barring Service) check being undertaken. This helped to keep people safe and ensure appropriate recruitments decisions were made when employing staff to work with vulnerable adults.

We looked at the service's health and safety file. All certificates and records for issues such as gas safety, water borne virus testing and electrical installations were up to date. We saw that equipment such as fire equipment; alarms and passenger lift were appropriately maintained and serviced on a regular basis. A fire risk assessment had been completed on Friday 22 April 2016 and we saw that the area manager had agreed and signed for all the essential compliance works to be undertaken.

Good

Is the service effective?

Our findings

People told us the staff supported them effectively, were well trained and met their needs. Staff consistently told us that they felt well trained to carry out their roles. Staff told us; "We look after people well here. We are well trained and provide good care." "We are well trained for the role. We receive regular training and can ask for courses of interest too." "We have lots of training. I feel that we are invested in."

We asked staff members about their induction programme. They told us they spent two weeks doing mandatory training courses and shadowing more experienced staff members prior to commencing work alone. There was an induction programme for new staff that included the Skills for Care Certificate. The certificate has been developed by a recognised workforce development body for adult social care in England. The certificate is a set of standards that health and social care workers are expected to adhere to in their daily working life.

We looked at the training and support in place for staff. We asked the registered manager to show us the training matrix. From our discussions with staff and from looking at training records, we found all staff received a range of appropriate training applicable to their role. This gave them the necessary knowledge and skills to look after people properly. Staff had access to training such as: infection control, moving and handling, fire safety, first aid, safeguarding, dementia, food safety and medication. Staff training was maintained and there were clear records to indicate when refresher training was scheduled to enable staff to maintain their knowledge and skills. CTL's had attended Mental Capacity Act and Deprivation of Liberty Safeguard training (DoLS) and were signed up to attend safeguarding and dignity level 3 training.

All the staff told us they received quarterly supervision and annual appraisal, and we saw documentation to confirm that this had consistently taken place. Staff told us they used supervision sessions to discuss their learning and development and to request further training. One staff member told us they were interested in working with people nearing the end of their life. They told us that they had requested training and were confident that this would be facilitated.

Langtree was designated to caring for people living with a diagnosis of dementia. We asked staff about their approach to dementia care and what model they followed at the service. A senior staff member explained that one model did not fit all and that they used a mix of approaches to ensure everyone was cared for in an individual and person centred way. We found the environment to be dementia friendly; there were signs to support people to orientate independently and we saw people walked about freely. There were appropriate reminiscence pictures on the walls and names, numbers and photos of people's choosing on the outside of people's bedroom doors to assist with orientation. A number of therapies were used at the service, such as using tactile hand-warmers containing different textures for people who enjoyed sensory experience, and doll therapy for those who found benefits in this. We saw people using and enjoying these therapies on the day of the inspection.

We saw that the care plans included a range of health and personal information. There was correspondence

and documentation about professional visits and appointments.There were care plans relating to communication, continence needs, sleep and daily routines. The files contained risk assessments for areas such as falls, skin integrity, nutrition and mobility. We saw that people's weight, nutritional intake and hydration were monitored. Any significant weight loss was recorded and instructions were in the files to guide staff on the next steps. People's appetites, likes and dislikes and particular dietary needs were recorded in the care files. We spoke with staff on Langtree and they demonstrated a clear awareness of everyone's nutritional needs and the reasons behind them.

We saw the home worked closely with other professionals and agencies in order to meet people's health needs. Involvement with these services was recorded in people's life plans and included Podiatrists, Opticians, Mental health teams, District Nurses, Physiotherapists and Doctors. A health care professional visited the home on the day of our inspection and confirmed that the home made timely referrals and staff demonstrated a good knowledge of issues when talking about people. We saw files contained a hospital transfer form with general and health information, which was to be sent with people if they needed to go into hospital. This was to help ensure people were looked after according to their needs and wishes.

We saw people had been asked to consent to their photograph being taken. When people were assessed as unable to provide consent, a best interest decision had been made and we saw people's photograph displayed in their file. We saw that one person had refused to give consent and there was no photo displayed in the person's file. This demonstrated the service's commitment to ensuring people's wishes were adhered to.

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 the 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.

People's capacity to consent was clearly documented and accompanied by a MCA assessment. MCA assessments were reviewed and updated every three months, or when changes occurred, and the reviews were complete and up to date. Where Do Not Attempt Cardiopulmonary Resuscitation forms had been completed, these were placed at the front of the files so that it was very clear to anyone looking at the file that this was in place.

The staff told us that DoLS applications had been made for all the people living on Langtree and we saw the documentation was kept in people's files. The manager had a DoLS matrix which identified when an application had been made, granted and expired. People's care file also had a sticker on it alerting staff to the authorisation. Staff we spoke with demonstrated a clear understanding of what having a DoLS authorisation meant for each person and why they were necessary. Staff were able to explain how people's capacity had been assessed and could identify what decisions people were able to make. Staff demonstrated a good knowledge of providing people with assistance and best interest decisions made on people's behalf. We saw that relatives had been involved in decision making and that a person had an independent mental capacity advocate (IMCA) because they did not have family involved.

We observed the breakfast on the residential unit and saw people were offered a choice of cereals and toast. People told us that they could have as much as they wanted and didn't feel rushed.

We observed the lunchtime meal on both units. We saw the meal consisted of an entrée of mushroom soup. People were then offered a choice of sandwiches or burger. Both meals were served with a salad garnish and it was blackcurrant and plum crumble or ice cream for dessert. On both the residential unit and Langtree, we saw the dining room tables were set nicely, with condiments. People were asked where they wanted to sit and were assisted to their places. Staff wore tabards to serve food and we saw them wash their hands frequently throughout the mealtime. The meal time was relaxed, people and staff were engaged in conversation throughout and there was a happy atmosphere in the dining areas.

We saw that people were given cups of tea and sugar and milk was put on the tables for people to help themselves. One person on Langtree made a mistake, putting too much sugar into their cup. This was dealt with sensitively without drawing attention to the person or their mistake. For example, the staff member offered the person a fresh cup of tea stating that the one they had was cold. The staff member returned with a fresh cup of tea but did not draw attention to the sugar by removing it and promoted the person's independence by enabling the person to put their own sugar in their cup.

People's dietary needs and preferences were adhered to. For example, one person was vegetarian and was given an alternative meal to the burger (a vegetarian burger) so that their needs were met, but they did not feel that they were eating a different meal to other people at the home. We saw people had chosen what they wanted to eat earlier in the day but some people had changed their mind when the food was given out. We saw staff immediately offered alternatives and people were satisfied with what they were then given. People told us; "You get a lot of choice but I prefer the summer menus." "I'm very happy with the food. It's excellent. We get fresh salmon and I love the gateau." "The food is okay. They ask you what you want and you get it."

People had been involved in choosing the homes décor in communal areas, such as the dining areas and lounges. People had also personalised their bedrooms and one person told us that the staff had put shelves up for them so that they could display their pictures and ornaments that were of sentiment to them.

Good

Is the service caring?

Our findings

We asked people and their relatives about the staff and the care provided. Without exception we received positive comments. People told us; "The home is excellent and the staff are brilliant. They treat me very well. I can't fault them for anything." "The staff are brilliant. They are all very caring and kind. I like to spend time in my room and they respect that. They check on me, day and night. They're so easy to talk to." "I've lived here many years. The staff are excellent. They are so kind to us. I don't sleep so good and they make me a cup of tea and help me settle."

Relatives told us; "The staff are very friendly. We didn't pick the home for its decoration. It was the manager. They put me at ease. How the manager and staff interacted with [person]. I knew it was the home for us." "I can't praise the staff enough. We've had no worries since [person] moved in here. We pick [person] up to take them out and they're always ready, they look nice and cared about." "I can't fault the staff. They're lovely."

We found the atmosphere in the home to be calm, welcoming and homely. Staff demonstrated a genuine fondness for people. A staff member told us; "I treat people as if they are my family member." We observed positive interactions between people and staff throughout the inspection.

Interactions between staff and people were not rushed. Staff demonstrated that they were patient and kind. Staff gave people eye contact and bent down to people when speaking. We saw staff providing reassurance and encouragement. People's independence was promoted by staff providing gentle reminders and prompts. For example, one person who used the service struggled to pick up their cup of tea. Instead of doing this for them, staff gently reminded the person to use both hands to pick the cup up. We saw that they responded to staff and managed it themselves.

We saw staff set their pace with people and walked very slowly to promote people's independence. People with walking aids were not rushed or encouraged to use wheelchairs to speed up the process. This helped people to retain their independence and dignity and demonstrated that staff acknowledged people's abilities and strengths. A person told us; "Staff encourage me to do things for myself but they also help me when needed." A staff member said; "People can do things for themselves and need assistance with other things. For example, some people need assistance with their bath but they can wash themselves. We provide assistance and encourage people to do what they can themselves."

We saw people were also confident to ask staff to do things for them. We observed one person ask a staff member for their blanket and the member of staff acknowledged their request and went to get it straight away. We observed the staff member cover the person and tuck the blanket around them. They asked whether the person was comfortable and offered a cup of tea. This showed us that staff encouraged people's independence but balanced this with the need to care for people and take practical steps to provide support.

People were treated with dignity and respect. A person told us; "The staff always knock on my door. If I want

some privacy and time to myself, the staff respect that." Staff described how they protected people's privacy and dignity; One member of staff said; "We make sure people are covered up when providing personal care, we knock before entering people's bedrooms and wait to be invited in. We always ask for the person's consent before doing anything."

People's relatives told us they were welcomed at the home and encouraged to visit whenever they wanted. One relative told us they maintained their support to their family member and would help them to bed at night or assist with personal care tasks. They told us [person] gained comfort from this. Staff recognised this was important to the person living at the home and their relative. We spoke with a second relative who told us several family members visited on a daily basis. The relative informed us that the communication was good and the service let them know of any changes or issues. They told us their relative was encouraged to join in with activities, was provided with good food and was looked after very well.

The home had communal rooms that people could use to spend time with their relatives. This included a quiet lounge downstairs and an upstairs lounge with a kettle and tea facilities on the residential unit. There was a lounge and garden that people could access through Langtree and we were told people's relatives were welcome to spend time with them in their bedrooms.

We saw evidence relatives had been involved in care review meetings and a relative told us that they were able to speak to staff or the manager whenever they needed to. Staff told us that family involvement varied as some people liked to be involved with care plan reviews, others liked to be present when GPs visited or took the person to appointments. Staff acknowledged some family members did not want to maintain that level of involvement.

Good

Is the service responsive?

Our findings

We asked people whether their individual needs were met. People told us; "I never wanted to go in to care but I'm happy here. They do for me what I physically can't do." "I've lived here for several years. It's great. I go the shops and the pub." "I'm happy with the care and support I'm receiving."

People and their relatives told us that an initial assessment had been conducted to ascertain their needs could be met prior to them moving in to the home. A person said; "They did an initial assessment and they asked me about my life." Relatives told us; "They asked about [person's] medical history and their needs. They got a history of them as a person; their likes, dislikes and social life."

Staff told us that people were encouraged to spend the day at the home prior to moving in. We were told that people would be invited to have lunch and meet other residents. This would enable people to familiarise themselves with the staff and determine if they liked the home. A relative told us; "We looked around the home first to assess its suitability for [person]. We were impressed and the manager answered all our questions. [Person] then spent five hours here and was showed their room. They liked it and it was a graded move from there."

We found care plans and records were individualised to meet people's preferences and reflected their individual needs from admission. Care files included personal information about people's background, family, working life, favourite places, hobbies, interests, religion and spiritual needs. We saw that people's choices were respected. For example, one person who used the service did not get up until lunch time. Staff told us that this was the person's choice. Everybody we spoke to confirmed that they chose when they wanted to get up or go to bed and staff supported this. We saw one person did not want their meal at lunch time. We heard staff tell them that they could have something later when they might feel more like eating. We saw documentation in people's files of how they would prefer their personal care to be met; a bath or a shower. Staff told us that if people refused either, they would try gentle persuasion and encouragement, but they would ultimately respect people's choice.

One person told us that they would like to be more mobile and independent. Their relative informed us that this had been explored and the manager had referred [person] to occupational therapy twice. We saw in the person's life plan that this had been documented and showed that people's views were captured and practical steps had been taken to support the person to achieve this.

We received positive comments from people who voiced that staff understood and supported their preferred daily living routines and care preferences. One person said, "I prefer to stay in my bedroom. They check on me and tell me what's going on downstairs but they respect my wishes." Another person told us; I have my own hairdresser come in. They let you do what you want."

People were supported to follow their interests and engage socially with others in ways that were meaningful to them. The home had a number of activities and outings on offer. On Langtree we saw people enjoying a sing-a-long. There were reminiscence aids, such as photos and pictures and the weekly Sparkle

newspaper, used to stimulate conversation. Doll therapy was also observed for people who responded to this. One of the carers who enjoyed leading activities had plans to try crafts with people as well as starting a book club where people could enjoy listening to a book being read to them.

We saw photos around the walls of outings that people had enjoyed in the past. There were also photos of themed weekends where people had been encouraged to eat food from a particular country, such as Mexican food, American fare and British fish and chips. All of these activities served to help keep people's minds stimulated and to occupy people in positive ways.

On the residential unit, we saw seven people engaged in chair exercises and laughing with each other. The ladies had bright coloured nails and they informed us they'd had a pamper day the previous day and their nails had been painted by one of the staff. We saw an activities timetable pinned to the noticeboard. Activities included; Crafts, exercise classes, finger nail boutique, games, trolley shop, bingo, cream tea, dvd's, book club and one to ones. A person told us that they would like to go on trips and we raised this with the manager following the inspection. We were told that activities had been discussed at the residents meeting and the current timetable had been derived with people living at the home. Trips had also been discussed at the meeting and were being explored regarding cost and viability. We looked at the resident meeting minutes which documented the discussion.

There was an appropriate complaints policy and procedure in place. We saw the complaints process displayed in communal areas. People and their relatives confirmed that they were aware of the complaints process but told us that they had not had cause for complaint. We saw the home had received three compliments thanking them for the care and support provided. Extracts from the compliments were; "Thank you for all the support you gave us as a family. We were able to relax knowing fantastic people were caring for our loved one." "Knowing that [person] was so well looked after was a huge source of relief. Please place on record a big big thank you to all the staff." "Thank you for the care and friendship you gave to [person]. They felt well cared for, safe and secure with what they regarded as "friends" looking after them."

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

The home had an established registered manager who had been in post for several years. They were knowledgeable about people's needs and familiar to people living at the home. This was reflected in the positive feedback we received when we asked people and their relatives what they thought of the management and whether the home was well-led. People told us; "The manager is easy to talk too. We see them all the time." The manager is very good. Approachable. They're excellent really." Relatives were as equally complimentary and told us; "We picked the home after meeting the manager. They encourage us to ring them anytime if we have questions or need help. "The staff and manager are approachable. You don't feel like you are bothering them and they're knowledgeable." "The manager is lovely. They all are."

Staff told us they felt supported, respected and involved in day to day decisions about how service was managed. Staff told us; "The manager is good. I wouldn't be here if they weren't." "The manager is approachable and supportive." "The manager is very supportive and the office door is always open." "The manager is amazing. They are approachable, supportive. They've been there for me. I can't sing their praise enough. The manager is interested in people's care. We can influence care and we should strive to improve and look for improvement."

We saw that staff meetings were held on a regular basis and appropriate records were maintained. We saw minutes of recent meetings where issues discussed included life plans, falls, consent forms, end of life, staff morale and medication. It was evident that the manager was visible and involved in every aspect of the home.

We saw resident meetings were conducted to enable and encourage communication from people living at the home to influence the care and support they received. We saw surveys had recently been given to people living at the home and sent to their friends and family. We confirmed that relatives we spoke with had received the survey. The manager explained the results would be analysed and used to drive improvements in the home in conjunction with the staff surveys.

We looked at the home's policies and procedures. The policies had been reviewed and were in the process of being updated. We saw the policies had been received and the manager had started to transfer them to the file. This would ensure staff and people had access to up to date information and guidance. Staff were made aware of the policies at the time of induction. We were told by staff that the policies file was always accessible to them if they required it for guidance.

The home had effective systems in place for quality assurance and audit. The registered manager conducted a number of quality and safety audits, which included reviews of accidents, the environment and

medication. The area manager also provided a further level of quality oversight by selecting a number of areas of the home and care files to audit. There was evidence that issues found were addressed to help maintain people's health and welfare. We saw that issues had been disseminated to the staff team through supervision and team meetings and issues identified were addressed within a clear time frame.

We saw that falls, accidents or incidents were monitored and triggers or trends were identified and evidenced. We saw learning from incidents or investigations took place and appropriate changes were implemented, including action taken to minimise the risk of further incidents. We found accidents; incidents and safeguarding had been appropriately and timely reported. We saw that the registered manager ensured statutory notifications had been completed timely and sent to CQC in accordance with legal requirements. The registered manager kept a file of all notifications sent to CQC.