Mrs W Collinson

Four Seasons Residential Care Home

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

Four Seasons Residential Care Home is a large detached house located in Littleborough, Rochdale. Personal care and accommodation is available for 16 people. There are 16 single rooms, with 12 rooms having en-suite toilet facilities. There were 13 people accommodated at the home during the inspection.

At the last inspection of March 2017 the service was rated as requires improvement overall with well-led in inadequate. These were five breaches in the regulations. Regulation 9 HSCA RA Regulations 2014 Person centred care. Care plans were not developed to meet people's identified needs. Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Failure to complete and return a PIR. Regulation 17 (2 (d) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2017 because fire drills were not recorded and Regulation 18 (4A) of the Care Quality Commission (Registration) Regulations 2009. Failure to notify the CQC of people subject to a DoLS and other required notifications. The service sent us an action plan to show us how they intended to improve the service. The service had improved and met the regulations at this inspection.

The service had 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service used the local authority safeguarding procedures to report any safeguarding concerns. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Recruitment procedures were robust and ensured new staff should be safe to work with vulnerable adults.

There were sufficient numbers of staff to meet people's needs.

The administration of medicines was safe and people received their medicines when they needed them. Staff had been trained in the administration of medicines and had up to date policies and procedures to follow.

The home was clean, tidy and did not contain any offensive odours. The environment was maintained at a good level and homely in character.

There were systems in place to prevent the spread of infection. Staff were trained in infection control and provided with the necessary equipment and hand washing facilities. This helped to protect the health and welfare of staff and people who used the service.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation

plan (PEEP) and there was a business plan for any unforeseen emergencies.

People were encouraged to eat and drink to ensure they were hydrated and well fed.

Most staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The person in charge was aware of her responsibilities of how to apply for any best interest decisions under the Mental Capacity Act (2005) and followed the correct procedures using independent professionals.

New staff received induction training to provide them with the skills to care for people. Staff files and the training matrix showed staff had undertaken sufficient training to meet the needs of people and they were supervised regularly to check their competence. Supervision sessions also gave staff the opportunity to discuss their work and ask for any training they felt necessary.

We observed there were good interactions between staff and people who used the service. People told us staff were kind and caring.

We saw that people were treated in a way that was suitable to their age, sex, gender and background.

We saw from our observations of staff and records that people who used the service were given choices in many aspects of their lives and helped to remain independent where possible.

We saw that the quality of care plans gave staff sufficient information to look after people accommodated at the care home and they were regularly reviewed. Plans of care contained people's personal preferences so they could be treated as individuals.

We saw visitors were welcomed into the home and people could see their visitors in private if they wished.

Some staff had been trained in end of life care which should enable them to provide support to people who used the service and their family at the end of their life.

Activities were provided which were suitable to the age and gender of people who used the service.

Audits, quality assurance surveys and meetings helped the service analyse performance to help improve the service.

There was a suitable complaints procedure for people to raise any concerns.

Staff and people who used the service said the home was well-led and the manager was approachable.

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 used the local authority safeguarding procedures to report any safeguarding issues. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Arrangements were in place to ensure medicines were safely administered. Staff had been trained in medicines administration and managers audited the system and staff competence.

Staff were recruited robustly to ensure they were safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS and should recognise what a deprivation of liberty is or how they must protect people's rights.

People were given a nutritious diet and said the food provided at the service was good.

Induction, training and supervision gave staff the knowledge and support they needed to satisfactorily care for the people who used the service.

Is the service caring?

Good

The service was caring.

People who used the service told us staff were helpful and kind.

We saw visitors were welcomed into the home and people could see their visitors in private if they wished.

We saw that people were offered choice in many aspects of their lives and told us they felt they were treated with dignity.

Is the service responsive?

Good

The service was responsive.

There was a suitable complaints procedure for people to voice their concerns. The manager of the home and area manager responded to any concerns or incidents in a timely manner and analysed them to try to improve the service.

People were able to join in activities suitable to their age, gender and ethnicity.

Plans of care were regularly reviewed and contained sufficient details for staff to deliver their care.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the quality of care and service provision at this care home.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

All the people and staff we spoke with told us they felt supported and could approach managers when they wished.

Four Seasons 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 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 was an unannounced inspection and was conducted by one adult social care inspector and one expert by experience on the 07 November 2017 and completed by one adult social care inspector on the 08 November 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, specifically working with older people and people living with dementia.

We requested and received a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. Notifications tell us about any incidents or events that affect people who use the service. We contacted the local authority and Healthwatch Rochdale who did not have any concerns about the service.

We spoke with six people who used the service, three relatives, two visitors, a cook, the deputy manager, a senior care staff member in charge of care plans and notifications and three care staff members.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the plans of care for three people and medicines administration records for eight people who used the service. We also looked at the recruitment, training and supervision records for four members of staff,

minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

All the people we spoke with said they felt safe at the service. Comments included, "Oh yes It's very safe here" and "Yes we are safe." A relative said, "The staff always have the right answers to any problems, I've never heard them raise their voice to anyone."

From looking at staff files and the training matrix we saw that staff had been trained in safeguarding topics. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service had a copy of the local social services safeguarding policies and procedures to follow a local initiative. This meant staff had access to the local safeguarding team for advice and the contact details to report any incidents. There was a whistle blowing policy and a copy of the 'No Secrets' document available for staff to follow good practice. A whistle blowing policy allows staff to report genuine concerns with no recriminations.

Staff we spoke with were aware of safeguarding issues and said, "I have completed safeguarding training. I am aware of the whistle blowing policy but fortunately I have not had to use it. If I saw any abuse I would definitely report it. I would go the authorities if it was the registered manager"; "I would report poor practice if I saw it" and "I have had my safeguarding training and refreshers. I would report poor practice using the whistle blowing policy. No choice I just would."

We observed that staff intervened should a person who used the service look unsafe by providing proactive care. On three occasions we saw people who used the service who had their walking aids within reach get up to start walking without them. Staff immediately intervened to remind people to use their aids to try to prevent a fall.

During the inspection we saw that people who used the service did not have to wait long when they requested assistance. On the days of the inspection we saw that there was a deputy manager, a senior care staff member, two care staff, a cook, a domestic and a maintenance man. The off duty rotas we looked at showed this was the normal number of staff on duty. We also saw staff had time to sit and chat with people who used the service. Staff told us, "There are enough staff here. We cover for each other"; "There are enough staff here to meet people's needs"; "There are enough staff to meet people's needs. We are very rarely short staffed" and "There are enough staff here to meet people's needs. It is very rare that staff are off sick or we are short of staff." This meant there were sufficient staff on duty to meet people's needs.

We looked at three staff files. We saw that there had been a robust recruitment procedure. Each file contained at least two written references, an application form with any gaps in employment explored, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision was taken to employ the person or not. This meant staff were suitably checked and should be safe to work with vulnerable adults.

At the last inspection the portable appliance test (PAT) had not been undertaken. This is a check to ensure all portable electrical appliances are safe. At this inspection we saw that this was completed and certification was in date. All other necessary checks had been completed. These included gas and electrical installation, the fire alarm system, call bells, the emergency lighting system, hoists and the lift. This ensured that the environment was checked at least yearly by qualified personnel.

There was an up to date fire risk assessment. At the previous inspection fire drills had not been undertaken regularly. This meant some staff may not have been aware of what to do in the event of a fire. Also people did not have an up to date personal emergency evacuation plan (PEEP). We saw that these shortfalls had been rectified at this inspection. A PEEP tells the emergency services what needs a person has if they need to be evacuated and was available for each person. Fire drill records showed staff participated in the drills which were held regularly.

There were environmental audits to check the service was safe which included the recording of hot water outlets, fire escape routes were accessible and windows were restricted from opening too far to prevent accidental falls. At this inspection there was a business continuity plan. The business continuity plan told us who the plan was for, what type of event could activate the plan, for example the loss of the kitchen and for any emergencies that may arise from floods, loss of electricity or gas supply, and extreme weather. There was a form for staff to complete to judge the impact an emergency may have on the service and the names and numbers of all staff who may need to be contacted.

There were policies and procedures for the control and prevention of infection. The training matrix showed us most staff had undertaken training in the control and prevention of infection control. The service used the Department of Health's guidelines for the control of infection in care homes to follow safe practice. The registered manager or other senior staff conducted infection control audits and checked the home was clean and tidy.

A person who used the service told us, "You leave your clothes to be washed and they are back the next day." There was a laundry sited away from any food preparation areas. The laundry contained sufficient equipment to help keep people's clothes clean and presentable. The industrial type washing machines had a sluicing facility to safely clean contaminated linen. There were hand washing facilities in strategic areas for staff to use in order to prevent the spread of infection, including the laundry. Staff had access to personal protective equipment (PPE) such as gloves and aprons and we saw that there were plenty of supplies. We observed staff used this equipment when they needed to.

People who used the service told us, "Our medication is locked away and they bring it to us" and "They bring our medicine to us."

The service used the National Institute for Clinical Excellence (NICE) guidance for the administration of medicines which is considered best practice for the safe handling of medicines. Staff also had patient information safety leaflets and access to the British National Formulary to get information about side effects or what a medicine was for.

We observed a member of staff administering medicines and saw they used safe procedures. We looked at the policies and procedures for the administration of medicines. The policies and procedures informed staff of all aspects of medicines administration including ordering, storage and disposal. All staff who supported people to take their medicines had been trained to do so and had their competency checked to ensure they continued to safely administer medicines. A senior member of staff regularly audited the system and the pharmacist who supplied the home with their medicines came into the home to audit the system annually

and were available for advice.

We looked at the medicines administration record (MAR) for eight people and did not find any omissions or errors. The records clearly identified what the medicine was for, at what time it should be given and the dose. Staff signed the chart when the medicine had been taken. We also saw that two staff checked medicines to look for any errors when they were sent from the local pharmacy.

At the last inspection 'as required medicines' (PRN) did not give staff sufficient information for staff to safely administer them. We saw at this inspection that for each PRN there was a protocol which informed staff who the medicine was for, what the medicine was for, the dose and how often it could be given in a 24 hour period. This ensured the administration of PRN medicines was safe.

Although there was a controlled drug cupboard and register nobody at the service required any of these stronger medicines. Likewise there was no person who required food supplements, wound dressings or drink thickeners which should be stored separately.
The medicines were stored safely in a locked room. The temperature of the room was recorded as was the dedicated medicines fridge to ensure they were stored within manufacturer's guidelines. We saw from looking at the records that medicines were stored within the recommended limits.

Any medicines which required a use by date had the initial date recorded to ensure staff were aware of what to dispose of it. Any unused medicines were safely returned to pharmacy. Staff signed a signature list to enable managers to follow up on any errors.

We saw that topical medicines such as ointments were recorded in the plans of care. The service used body maps to show staff where to apply the medicines.

Good

Is the service effective?

Our findings

For part of the inspection we sat in the dining room completing paperwork and observed a lunch time. We saw staff interacted well with people who used the service, brought them their choice of meal and there was a sociable atmosphere people could enjoy. We saw that people enjoyed what looked like a hot nutritious meal and emptied their plates. All the people we spoke said the food was generally good and tasty. We asked people at the home what they thought of the food. Comments included, "The food is good"; "I enjoyed mine" and "We are well fed so I'm not grumbling, but I'd like bacon and egg for breakfast sometimes but the only choice is cereal, toast and juice. I had cornflakes today." We were told the registered manager was on compassionate leave and therefore not available for any comments. We suggested to the person in charge that the introduction of a cooked breakfast option could be brought up at a meeting.

Two relatives we spoke with said, "Our relative likes the food, if there is something she doesn't like the staff always make her something else" and "Our relative gets breakfast in bed if she wants." People who used the service told us, "I go to the dining room for meals but I can have my meals in my room If I want" and "They come around and ask what meals we want for the next day." The cook said, "We always have items in stock that we can make to order such as fish fingers and baked potatoes. I make omelettes as well if residents ask for one." People were offered a choice of meal and where they sat to eat.

There was a three weekly menu cycle which the cook said was changed seasonally. There was an option at each meal. We observed the cook doing her rounds and asking people what they wanted for the next meal.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. The plans of care contained details of any special needs a person had with their intake of food and drink. We saw there was reference in the plans of care where specialists such as dieticians, and Speech and Language Therapists (SALT) had provided advice and guidance for people who had any special dietary needs and people's weights were recorded regularly to ensure people were not gaining or losing weight.

The kitchen was rated as five star, very good from the last environmental health inspection which meant food ordering, storage, preparation and serving were safe. We went into the kitchen and found it to be clean and tidy. We saw there was a good supply of fresh, frozen, dried and canned foods. This included fresh fruit which was made available daily and was taken around on the drinks trolley.

Tables were set attractively with tablecloths, cutlery, serviettes and a flower arrangement. We asked why people did not have any condiments on the table. A member of staff said, "Residents can sit where they want and some of them will put on too much salt or pepper ruining their meal. We have condiments and provide them if the residents ask." We were shown a cupboard where the condiments were kept and ascertained that they were readily available to residents on request. There were sufficient condiments sets for each table if needed and we observed one person who asked for salt got it.

We toured the building during the inspection and visited all communal areas, several bedrooms and the

bathrooms. The home was clean, tidy and fresh smelling. There was equipment to aid people with their mobility needs and staff had been trained to use it. We were shown many areas where the home had been decorated or refurbished which included new flooring and chairs. We were told new arm chairs had been ordered. All the furniture we looked at was in good order.

We visited all communal areas and several bedrooms. Communal areas were homely and bedrooms had been personalised to people's tastes with photographs of family, ornaments and personal belongings. One person told us, "I have a lovely room and a nice view."

There was a choice of bath or shower. The bath was suitable for people who had mobility needs. There was a garden area for people to use in good weather with seating and tables. There was a lift to ensure people were able to reach both floors.

There was a system for repairing or replacing any broken items and a person employed to undertake maintenance work.

People who used the service told us they had access to health care professionals and commented, "The optician comes and looks at our eyes"; "If I say I want to see a Doctor they come within a day" and "The podiatrist come regularly to see people, I just ask and they come to me as well." We looked at three plans of care and found people had access to healthcare professionals such as hospital consultants and arrangements were made for routine appointments to ensure people's needs were met.

Incidents and accidents were recorded and investigated. The records showed us what action the service had taken and what they did to try to prevent any further accidents such as ordering pressure mats which let staff know when people are moving in their rooms, moving furniture around to make access safer and the use of technology. An infra-red sensor was placed in a person's room which would let staff know if the person was mobile.

At the last inspection people had not signed their agreement to care and treatment. We saw that every person who could had now signed their agreement and those people who did not have the mental capacity to agree for their care either had a family member who had power of attorney to act upon their behalf or been subject to the Deprivation of Liberty Safeguards procedure. All three plans we looked at had been signed by the person who used the service. However one person who used the service said, "My family have power of attorney and look after all that. They weren't happy with where I was before so they arranged for me to come here about two years ago. It's much better" and a family member commented, "We are fully involved in care planning and the DoLS application."

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (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).

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. Most members of staff had been

trained in the Mental Capacity Act 2005 (MCA 2005).

At the last inspection the service had not completed notifications to the CQC as required by the regulations for people who required a DoLS decision for staying at the home. At this inspection each person had a mental capacity assessment which was reviewed regularly. We saw that ten people had a DoLS in place and two applications were awaiting a decision. The notifications were being sent to the CQC.

All staff who commenced working at the service were given an induction. This included familiarisation with the home including fire exits, use of the call bell system, using the telephone, reception of visitors, the rota and request book, staff and their roles, wages, staff routines, the resident information booklet, the communications book, understanding and reading the care notes, equality and diversity, handovers and the employee handbook. Staff were then enrolled on a diploma in health and social care. The staff we spoke with had worked at the home for some time but told us they had completed an induction when they commenced work and were supported until they were confident working at the home.

The staff we spoke with said, "I have completed all the mandatory training. I think the training we have is sufficient to meet people's needs. I have had dementia training. We had medicines training from the pharmacist"; "I have completed all the usual training and have had training for people with a dementia. Three more staff are completing end of life care at the local hospice" and "I think we have done enough training to do the job. We do the training every year but there are some changes."

We saw from looking at the training matrix, staff files and talking to staff that training was ongoing. Most staff had completed training for fire safety, DoLS, mental capacity, care of people with dementia, hand hygiene, falls prevention, first aid, moving and handling, health and safety, safeguarding, medicines, food hygiene and infection control. We also saw the training planning list which showed us training was arranged for MUST (diet and nutrition), pressure area care and basic life support. Most staff also had an NVQ or diploma in health and social care. This meant there was a good skill mix of staff to meet people's needs.

Staff we spoke with told us, "I have supervision regularly and I have a chance to have my say"; "Part of my role is to supervise staff and I have one to ones with the registered manager regularly"; "I have my supervision regularly. You have a discussion. It is not a disciplinary" and "I have had my supervisions. It is a two way discussion."

At the last inspection staff did not receive formal supervision and so could not demonstrate what support and opportunities they were given. At this inspection we found staff were receiving supervision almost monthly and a yearly appraisal, which ensured they could bring up any issues or training needs they had.

Plans of care showed the service liaised well with other organisations and any admissions were only completed after assessment. One staff member told us they had a good rapport with district nurses and said the district nurses thought the service was brilliant. The service held a basic fact sheet about each person and would photocopy the medicines record to send with people if they needed to. This meant other organisations would be aware of people's basic needs if they were needed in an emergency.

Nobody currently residing at the service had any non-verbal communication needs or required the use of restraint.

Good

Is the service caring?

Our findings

A person who used who used the service said, "You can't fault the place." Visitors we spoke with told us, "It's like a big family here, I'm always made to feel welcome and so are my family, I feel like we are part of a team" and "They keep my relative immaculately clean and tidy. I come at all times of day and night and have never found her any different." A visitor who was holding a group service to support people's religious needs said, "We come every Tuesday, we are here by invitation and are always made to feel welcome by the staff." All the people we spoke with thought staff were caring and kind.

Staff we spoke with said, "I would be happy for a relative to live here. I like working here. I love it here because of the satisfaction of helping people. They are like family"; "I love it here. I like the home and the people. It never feels like work"; "I like it here. It is lovely" and "I like working here. I like looking after older people. I would be prepared to let a member of my family live at the home." Staff enjoyed working at the home.

We checked to see if any person accommodated at the home had any differing ethnical or cultural needs. However nobody currently accommodated at the home had any specific needs other than their slightly different spiritual needs which we saw were met by providing different religious ministers. On the first day of the inspection we saw a religious group holding a service which was well attended and enjoyed by many of the people who used the service. This was an interdenominational service which a person from any religion could attend and included prayers and hymns.

We observed staff during the inspection. We did not see any breaches of privacy. We saw that apart from one occasion staff clearly asked a person what they wanted them to do and waited for a response before continuing with any task. For example going to the toilet. We saw one person was assisted back to eat her lunch. Staff used gentle persuasion and then left the person to eat independently. We saw staff were kind, compassionate and had a good rapport with people who used the service.

On the one occasion we did see a member of staff act without talking to the person we told the senior member of staff on duty. We had observed this member of staff communicating well with people previously. The staff member told us, "I just adjusted her slipper as I saw it was coming off and I was helping the lady next to her at the time." The staff member acted out of kindness and for the safety of the person.

People were able to come and go as they pleased, could choose what they wanted to eat or drink and wore clothes suitable to their age and gender. Plans of care informed staff to ask people what they wanted to wear prior to assisting them. We saw one person applied their own creams. We also saw in the plans of care other tasks people could do themselves without staff intervention such as cleaning their own teeth or if they liked to join in activities. This helped people retain some independence.

We saw from the plans of care we looked at that people's likes, dislikes and past history was recorded so that staff had the necessary information to treat people as individuals.

We saw that staff were taught about confidentiality topics, had confidentiality policies to support their practice and that records were stored securely so only allow people who needed access to the documents were able to do so.

A relative we spoke with said, "There are no restrictions on me visiting, whenever I come there are no smells and it's always clean." Visiting was unrestricted and people could take visitors in the communal areas or their rooms if they wished privacy. People who used the service were encouraged to remain in contact with their family and friends.

We saw that there were colouring books and crayons in the entrance hall and asked why. A staff member said, "We welcome and encourage children to come, they are for them to use to do drawing and colouring with the residents."

There was a range of information in the entrance hall including a document which was given to people when they were admitted. This gave people the details of the services and facilities offered at this care home, including the complaints procedure and helped people make an informed choice to live at Four Seasons Residential Home.

Good

Is the service responsive?

Our findings

There was a suitable complaints procedure accessible to people who used the service and their relatives. The complaints procedure told people how to complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of the Care Quality Commission.

Nobody had any concerns on the day of the inspection. The CQC had not received any concerns about the service and the service had not received any complaints themselves. However there was a system for investigating complaints should the need arise. All the people we spoke with felt able to talk to any member of staff or management if they had any concerns.

We saw that staff responded to people's individual needs with the use of comfort twiddle muffs and activities blankets. This equipment helped people to relax.

The staff member for developing and updating care plans said, "Families and people who use the service can be involved in the care plans and when we update it" and a family member confirmed staff kept them up to date with any changes. We looked at four plans of care during the inspection. Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Information was also obtained from other health and social care professionals such as the person's social worker. Social services or the health authority also provided their own assessments to ensure the person was suitably placed. We saw that the assessments had been fully completed for each person. This process helped to ensure that people's individual needs could be met at the home.

The plans of care showed what level of support people needed and how staff should support them. Each heading, for example personal care, mental health, diet and nutrition, mobility or communication showed what need a person had and how staff needed to support them to reach the desired outcome. The plans were reviewed regularly to keep staff up to date with people's needs. The quality of care plans was regularly audited by management. There was a daily record of what people who used the service had done or how they had been to keep staff up to date with information. An existing member of staff was now employed three days a week to ensure the care plans and other documentation was up to date and this showed how the service was improving. This member of staff did not have 'floor duties' on the three days.

Staff we spoke with told us, "We have staff handovers. We discuss the day in general, any medicines changes or what they have been up to. Also if they have needed the doctor"; "Information is passed over through the communication book and handovers but if something happens you can phone the registered manager at any time" and "We pass over all information at staff handovers. Three times a day. We also have a diary to record any important information. Staff have to read and sign it." Information about the care and any changing needs of each person was communicated through staff handovers and a dairy. This meant staff were aware of what people needed.

There was a series of planned activities at the care home which were advertised on a wall in the dining room. There was a staff member purely to provide activities and entertainment but was not available during the inspection. People who used the service told us, "I get my nails done every week on the pamper day" and "It was a change when the snakes came" This referred to a visit by the group called Zoo Lab. Relatives we spoke with said, "Staff are wonderful mum particularly likes the quizzes they do"; "They invite families to come to events, we were invited to come to the Zoo Lab"; "Entertainers come regularly" and "The Halloween night was good. They organise current events like one for bonfire night." The activities a person attended was recorded so staff knew what went well.

Activities included, "Going out with relatives, were visited, pamper sessions to have a 1 – 1 chat, zoo lab, a dementia friendly activity product book which staff were able to order from occasionally, doll therapy, entertainers, going out to the theatre, film nights, reminiscence therapy, hairdressing, arts and crafts, quizzes, bingo and completing jigsaws. An annual summer fair was held and children came into the home from local schools to entertain the people who used the service. We observed many times that staff sat and talked to people on topics not related to care. Although music was not played at lunch time we saw staff quickly put on some relevant music when a person asked and the television was on for people who wanted to watch it. People were able, if they wished, to join in activities they could enjoy.

Four staff had completed end of life care and a further three staff were completing the course. This course was provided by the local hospice and considered to be best practice in this area. This training would give staff the knowledge to care for people at the end of their lives and support bereaving families.

The three care plans we looked at showed that a person's last wishes had been recorded with details such as the person responsible for any arrangements, a preference for funeral director or if a person wanted burial or cremation. This should ensure people received the care they requested.

Good

Is the service well-led?

Our findings

The service had 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not available during the inspection which we were told was due to compassionate leave. However, due to the new staffing arrangements and support from the registered manager we could see that the service had improved since the last inspection.

At the last inspection of March 2017 the service were rated as inadequate for this domain. This was because paperwork was not completed such as fire protection documents or a business continuity plan, not completing the PIR, not sending in required notifications and incomplete quality assurance audits. The registered manager and another member of staff, with support from the deputy manager had looked at the shortfalls and made improvements.

A relative said, "The manager is very approachable, I've no complaints, actually they come to me if they have any worries." All the people we spoke with knew who the registered manager was and the overriding consensus was that all staff were approachable. We observed staff knew people who used the service and family member's names and they called staff by their first names. This showed us staff knew everyone well and most had worked at the service for some time.

Staff we spoke with said, "There is a good staff team and good management. The registered manager is fine. She is approachable and supportive"; "The managers are supportive. The registered manager is lovely and very approachable"; "I get good support from the registered manager. She is approachable" and "We have learned lessons since the last inspection. Since the last inspection I now have three days a week to complete paper work, care plans and monthly reviews, ordering and returns of medicines, audits, supervision and appraisal and completing DoLS applications. I am not working the floor when I do this. The manager is OK. She is very supportive of what I am doing." Staff felt supported and by selective delegation staff were more involved in maintaining and improving the service.

We looked at some policies and procedures which included key ones, for example, confidentiality, safeguarding, Mental Capacity and DoLS, whistle blowing, equal opportunities, data protection, health and safety, social networking, smoking on duty, medicines, infection control, handwashing, religion and spiritual needs. We saw the policies and procedures were updated and available for staff to follow good practice.

A statement of purpose was available to inform professionals of the registration details of the service, key staff and their contact details, the range of staff and qualifications, the organisational structure, aims and objectives, the facilities and services offered and the complaints procedure. The service displayed their current rating although did not have a website which the rating could be displayed upon.

The registered manager or a senior member of staff conducted regular audits. The audits included infection

control, cleanliness of the home, plans of care, medicines administration, the environment for any hazards such as hot water temperatures, health and safety, wheelchair safety, mattress covers, fire safety and training and supervision. The audits helped the service maintain or improve standards.

Staff told us, "We don't have regular staff meetings but we get to know all that is going on" and "We don't have a lot of formal staff meetings but we get to know everything with handovers, the diary, 1 – 1's and just day to day chats." This is a small family run home and although staff meetings were not held regularly they felt they were kept up to date with what was happening at the home.

The registered manager sent out regular quality assurance questionnaires to people who used the service and staff. Staff responses were positive about working at the home, equality and diversity, paperwork and handling complaints. The last staff survey was in May 2017. People who used the service were asked questions around staff attitude, involvement in care, safety, were people listened to, confidentiality and other relevant questions. We saw all people either agreed or strongly agreed in a positive way to the questions asked. Comments included, "I feel happy and satisfied in every way"; "My care package is delivered professionally in a caring compassionate way" and "Activities are suitable." Where one person said the handles on their drawers had come off they were fixed when the maintenance person was told. This helped show the registered manager responded to the views of people who used the service.