Ramos Healthcare Limited

Hampton Court EMI Rest Home

Inspection report

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Date of inspection visit: 8 and 9 October 2015
Date of publication: 19/01/2016

Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This unannounced inspection took place on 8 and 9 October 2015.

Located in a residential area of Southport and close to the town centre, Hampton Court EMI Care Home provides accommodation for up to 26 people who are living with dementia. Accommodation is provided over three floors with the lounge and dining areas on the ground floor. A passenger lift provides access to the upper floors.

At the time of the inspection there were 25 people living at the home.

The registered manager had recently left the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said they felt safe living at the home and were supported in a safe way by staff. Families told us they

Summary of findings

were satisfied their relatives were safe and well cared for at the home. A family member said, "There are no problems. I leave knowing my mum is safe, cared for and happy." Families told us there was good security in the home. We observed staff constantly checking on people throughout the day especially the people who liked to walk about the building.

The staff we spoke with could clearly describe how they would recognise abuse and the action they would take to ensure actual or potential abuse was reported. Staff confirmed they had received adult safeguarding training. An adult safeguarding policy was in place for the home and the local area safeguarding procedure was also available for staff to access.

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults. People living at the home, families and staff told us there was sufficient numbers of staff on duty at all times. We observed that there was an adequate number of staff on duty throughout the inspection.

Staff told us they were well supported through the induction process and regular supervision. They said they were up-to-date with the training they were required by the organisation to undertake for the job. They told us management provided good quality training.

A range of risk assessments had been completed depending on people's individual needs. Care plans were well completed and they reflected people's current needs. Risk assessments and care plans were reviewed on a monthly basis or more frequently if needed.

Medicines were not fully managed in a safe way. For example, information was not available to show that people had consented to their medicines being managed by staff. Plans were not in place for everyone who was prescribed medicine only when they needed it. You can see what action we told the provider to take at the back of the full version of this report.

The building was clean, well-lit and clutter free. Measures were in place to monitor the safety of the environment and equipment.

People's individual needs and preferences were respected by staff. They were supported to maintain optimum health and could access a range of external health care professionals when they needed to.

People told us they were satisfied with the meals. We observed that people had plenty of encouragement and support at meal times. People were not rushed and staff took the time to talk to people during lunch. They also checked if people had enjoyed their meal.

Staff had a good understanding of people's needs and their preferred routines. We observed positive and warm engagement between people living at the home and staff throughout the inspection. A full and varied range of recreational activities was available for people to participate in. Some people helped with tasks about the home and this was encouraged and supported by staff.

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

The culture within the service was open and transparent. Staff said management was both approachable and supportive. Staff were aware of the whistle blowing policy and said they would not hesitate to use it. People and families described the staff as caring, friendly and approachable. Families said the home was well managed.

A procedure was established for managing complaints and people living at the home and their families were aware of what to do should they have a concern or complaint. No complaints had been received within the last 12 months.

Audits or checks to monitor the quality of care provided were in place and these were used to identify developments for the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Relevant risk assessments had been undertaken depending on each person's individual needs.

Staff understood what abuse meant and knew what action to take if they thought someone was being abused.

Safeguards were not robust enough to fully ensure the safe management of medicines.

Measures were in place to regularly check the safety of the environment and equipment.

There were enough staff on duty at all times. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

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

People told us they liked the food and got plenty to eat and drink.

People had access to external health care professionals and staff arranged appointments readily when people needed them.

Staff said they were well supported through induction, supervision and on-going training.

Is the service caring?

Good

The service was caring.

People and families told us they were happy with the care they received. We observed positive engagement between people living at the home and staff.

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

Is the service responsive?

Good

The service was responsive.

Summary of findings

People's care plans were regularly reviewed and reflected their current and individual needs. We observed that care requests were responded to in a timely way. Families told us staff communicated with them in a timely way if there were any changes to their relative's needs.

A wide variety of recreational activities was available for people living at the home to participate in. These included group activities and activities specific to people's preferences and skills. Staff supported people to retain their interests once they moved to the home.

A process for managing complaints was in place. No complaints had been received within the last 12 months. Families told us they could provide feedback about the services at the 'Resident's meetings'.

Is the service well-led?

Good

The service was well led.

Staff spoke positively about the open and transparent culture within the home. Staff and families said they felt the home was run well and that the manager was approachable.

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

Processes for routinely monitoring the quality of the service were established at the home.

Hampton Court EMI Rest 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 unannounced inspection took place on 8 and 9 October 2015.

The inspection team consisted of an adult social care inspector and an expert by experience with expertise in services for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. This usually includes a Provider Information Return (PIR) but CQC had not requested the provider (owner) submit a PIR. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service to see if they had any updates about the service.

During the inspection we spent time with nine people who were living at the home and two family members who were visiting their relatives at the time of our inspection. We also spoke with the manager, a senior care worker and two care staff. In addition, we spoke with the activity coordinator and the chef.

We looked at the care records for seven people living at the home, four staff personnel files and records relevant to the quality monitoring of the service. We looked round the home, including some people's bedrooms, bathrooms, dining rooms and lounge areas.

We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide verbal feedback due to needs associated with cognition and memory.

Requires improvement

Is the service safe?

Our findings

The people we spent time with who were able to verbalise their views told us they felt safe living at the home. Families told us they were satisfied their relatives were safe and well cared for at the home. A family member said, "There are no problems. I leave knowing my mum is safe, cared for and happy."

The manager provided us with an overview of how medicines were managed within the home. Processes were established for receiving, stock, monitoring stock and the disposal of medicines. Medicines were held in two locked trolleys in the corridor on the ground floor. The trolleys were secured to the wall. Medicines were administered individually from the trolleys to people living at the home. Staff wore a red tabard to highlight they must not be disturbed while giving out medicines.

The medication administration records (MAR) did not include a picture that was sufficiently large enough to identify the person. This is important in asetting where people are living with dementia so staff can correctly identify the person the medicines are for. We noted that the MAR charts had been completed correctly and in full.

Medication requiring cold storage was kept in a dedicated medication fridge. The fridge temperatures were monitored and recorded daily to ensure the temperatures were within the correct range. No medicines requiring refrigerated storage were in use at the time of the inspection.

Arrangements were in place for the safe storage and management of controlled drugs. These are prescription medicines that have controls in place under the Misuse of Drugs Legislation. Nobody was prescribed controlled drugs at the time of the inspection. A small number of people were prescribed topical medicines (creams). These were stored safely but body maps were not being routinely used to show where topical creams should be applied.

Two people were receiving their medicines covertly. This means that medication is disguised in food or drink so the person is not aware they are receiving it. A mental capacity assessment had not been completed to confirm the person lacked capacity to make decisions about their medication. The person's GP had provided a written agreement for the administration of the medication in this way. The decision was also discussed with the person's family. Pharmacy had provided advice for just one person receiving their medicines covertly. It is important that pharmacy are involved to provide advice as some tablets do not work as well if, for example, they are crushed or if placed in hot drinks. A plan was not in place for each person to guide staff in how to administer the medication covertly.

Of the MARs that we looked at, we noted that five people prescribed medicines only when they needed it (often referred to as PRN medicine) did not have a plan in place to guide staff about when this medication should be given. PRN medicine was mostly prescribed for pain or if people became upset. It is important that a plan is in place as often people living with dementia cannot say if they are pain or upset, and staff need to be able to understand what signs to look out for. We also noted that some people were receiving PRN on such a regular basis that it had become a routine medicine. There was no evidence that the GP had reviewed the PRN medicines to determine if it should be prescribed on a regular basis.

A process was in place for auditing the medicines each month but it had not identified the issues we found. This was because the audit structure was limited in that it did not include prompts for checking arrangements, such as PRN plans and covert medicines.

Not ensuring effective safeguards were in place for the safe management of medicines was a breach of Regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A medicines policy was in place but it was out-of-date and did not reflect current national guidance. The provider showed us the new medicines policy that was due to be released company-wide. It took account of the NICE guidance for managing medicines in care homes. NICE (National Institute for Health and Care Excellence) provides national guidance and advice to improve health and social care.

We asked people what they would do if they felt they were being treated in an unkind way. A person said, "I would report it to one of the girls [staff]." We asked the same of a family member and they said, "I'd report it to social services and mum's social worker."

Throughout the inspection we observed staff engaging with and supporting people in a kind and patient way. We noted that staff checked on the people who liked to frequently walk about the building. There were times when people living at the home became annoyed with another

Is the service safe?

person living there. Staff intervened quickly and used distraction to diffuse the situation, thus avoiding a potential incident. The home was secure and included a key pad lock to enter and exit the building.

The staff we spoke with could clearly describe how they would recognise abuse and the action they would take to ensure actual or potential abuse was reported. Staff told us, and training records confirmed, they had received adult safeguarding training. A member of staff said if they were concerned about how people were being treated they, "Would take it to a senior member of staff. If it went unheard I would go to the owners." An adult safeguarding policy was in place for the home and the local area safeguarding procedure was also available for staff to access. The local area contact details for reporting a possible safeguarding concern were displayed on the notice board in the office.

Throughout the inspection we observed sufficient numbers of staff on duty to ensure people's needs were met in a timely way. People were not rushed when staff were supporting them. They told us staff responded quickly if they needed support. One of the people said there were too many staff. Families were pleased with the staffing levels and said there was enough staff to ensure their relative was safe and well cared for. A family member told us they called in at various times and there were always enough staff around.

Equally, staff told us they felt the staffing levels were adequate. A member of staff said, "There is always plenty of staff on shift. We are never left short. The manager finds cover if someone rings in sick." Another member of staff said, "We can get things done to a high standard because you have plenty of time to give to each resident what they need."

The manager advised us there were three care staff and the manager on shift each day and a senior carer and three care staff on duty at the weekends. The activity coordinator worked most days but could be flexible depending on the activities planned. A chef, kitchen assistant and housekeeper were also on duty each day. Two care staff worked during the night. A dependency assessment was complete for each person. This was regularly reviewed to check for changes in the person's dependency.

The care records we looked at showed that a range of risk assessments had been completed and were regularly reviewed. These included a falls risk assessment, mobility/ stairs assessment, nutritional assessment and assessment for risks outdoors. Care plans related to risk were in place to provide guidance for staff on how to minimise the risks for each person. Information sheets were located in the care records for specific conditions that place a person at risk, such as epilepsy and diabetes. The manager said staff had not had specific training in epilepsy but were up-to-date with first aid training so could respond to emergencies.

We did note that the care plans regarding diabetes lacked detail in terms of how staff would recognise and respond if a person was experiencing, for example, a low blood sugar episode. Although generic information was in place, it was not specific to the person. We discussed this with the manager during the inspection who agreed to further develop the care plans. Detailed care plans were in place regarding the management of risk associated with epilepsy. However, these plans were located with the medication records so were not as accessible as they would be if they were stored in the care records. The manager said they would place a copy of the plans in the care records also.

We looked at the personnel records for four members of staff recruited in the last year. We could see that all required recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff. Interview notes were retained on the personnel records. Two of the personnel records did not contain a photograph of the staff member and we highlighted this to the manager at the time of the inspection.

We had a look around the home and observed it was clean, clutter free and well maintained. Families we spoke with were pleased with the cleanliness and upkeep of the home. A family member said to us, "There's always somebody doing odd jobs and you see the cleaners all the time." Another family member said, It's like being in a hotel; happy, clean and bright."

A health and safety policy statement was dated 10 July 2015. We noted that an environmental risk assessment was carried out in November 2014. A checklist was in place outlining when checks or service tests had been completed and when they were next due. We noted that a range of

Requires improvement

Is the service safe?

internal environment and equipment safety checks were in place. For example, electrical portable appliance testing was undertaken in March 2015. Water safety was checked on a regular basis as was the safety of the passenger lift.

A fire risk assessment and plan had been developed for each of the people living at the home. A fire roll-call was in place and a copy located in the foyer. It indicated what level of support each person required in the event of an evacuation. All the people residing on the top were fully ambulant to support an efficient and safe evacuation. A fire risk assessment was undertaken in August 2015. Fire procedures were in place for both day and night. Records showed that fire drills took place twice a year. Staff were up-to-date with fire training. A full fire alarm system check and an emergency lighting periodic inspection took place in April 2015. Records showed that the maintenance person carried out regular checks and tests of the fire alarm system, including fire door guards and the fire door release mechanisms. Staff we spoke with had a good understanding of what to do in the event of a fire.

Good

Is the service effective?

Our findings

Due to needs associated with memory loss, most of the people living at the home were unable to verbally share with us whether they were supported to maintain good health care. Families we discussed this with were satisfied that the staff monitored their relative's health care needs and took action when needed. A family member said, "They [staff] are on the ball. This week [relative] showed signs of a urine infection. The doctor visited and started antibiotics." Regarding the health of their relative, another family member told us, "Staff ring us and send for the doctor."

From our conversations with staff it was clear they had a good knowledge of each person's health care needs. People's care records informed us they had regular input from professionals if they needed it, including the GP, optician and chiropodist. A form was in place to record all consultations with health or social care professionals. We could see that some people received specialist health care input if they needed it. This included input from the local community mental health team.

We spoke with a member of staff who started working at the home approximately 12 months ago. They described a thorough induction that involved shadowing a more senior member of staff for three weeks. They said they spent time getting to know the people living at the home and familiarising themselves with "how everything worked". Induction records were located in the recruitment records we looked at.

Staff told us they were provided with good training that supported them in their role. A member of staff said, "The training here is brilliant. It's non-stop." Staff also told us they were encouraged and supported with undertaking National Vocational Qualifications (NVQ) relevant to their role. We heard from staff that they received regular supervision and an annual appraisal. Records confirmed that staff were up-to-date with training and the manager had a system in place to monitor the status of staff supervision. The manager carried out competency checks for the staff who were trained to administer medication.

We spent time in the dining room with people when they were having their lunch. The people we spoke with were complimentary about the food. They said they enjoyed their lunch and got plenty to eat. One of the choices was white fish with cauliflower cheese and mashed potato. One person was not eating it. We did note that it was all light coloured food on a white plate and it appeared the person was unable to identify what they were eating. Once we explained what it was, the person readily ate it. Drinks were provided with the meal.

There was plenty of staff to support people who needed it so the lunch time was calm and unhurried. There was constant chat between staff and people. When one of the people was reluctant to eat a member of staff offered alternatives and then spent time with the person encouraging them to eat.

We spoke with the chef who advised us that summer and winter menus were in place. The chef told us they asked the person and/or their families their food preferences when they first moved into the home. The chef said snacks were available all the time. They said, "Biscuits, crisps, sandwiches, anything they ask for." The chef made their own cakes and we observed a batch of buns had been made that day.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Throughout the day we heard staff appropriately seek people's consent before providing day-to-day care. For example, we heard staff ask people if they wished to take their medication or join in an activity.

For more complex matters, a mental capacity assessment had been undertaken to assess the person's capacity to make decisions. We observed that the following standard phrase was used in each capacity assessment – "Although [person] fails to retain important information regarding finances but is still able to make choices of what clothes to wear and what food to eat". We discussed with the manager that using such a standard phrase was not in keeping with the spirit of person-centred practice. Furthermore, the phrase was limiting as it only identified that the person needed support with decision making around finances. The manager said they would review the mental capacity assessments and revise them in accordance with each person's needs.

Good

Is the service effective?

Staff told us that some people's wishes regarding their end of life care were known, including their decisions about resuscitation. We could see that Do Not Attempt Resuscitation (DNAR) plans were in place for some people. These had been led by the person's GP.

The registered manager advised us that applications in relation to Deprivation of Liberty Safeguards (DoLS) had been submitted to the Local Authority for each of the people living at the home. Some of the DoLS had been authorised and they were awaiting a DoLS assessment for other people. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

The manager confirmed that the staff team had received training in the Mental Capacity Act (2005). The staff we spoke with confirmed they had received training and they demonstrated a good understanding of The Act.

We had a look around the home to see if the environment was suitable for people living with dementia. It was spacious and bright, with plenty of space for people to walk about in. Colour had not been particularly used in a way that could assist people to find their way about or locate various rooms. For example, doors were beige coloured and walls were cream. This was something the manager said could be considered when redecoration was taking place. There was some accessible signage in use and the manager said they were looking into purchasing further signage.

Good

Is the service caring?

Our findings

Not many people were able to verbally articulate their views about how staff engaged with them. When we asked if they were happy with the way staff cared for them people said they were. Families also spoke positively about the caring attitude of the staff. They said there was no restriction on visiting times and they could visit whenever they wished.

Throughout the inspection we observed people readily approaching staff and staff taking the time to engage in conversation with people. Staff were kind and caring in the way they engaged with people. Conversations between staff and people living at the home were jovial and upbeat; people smiled and laughed a lot with staff. Staff gave people time to express themselves and actively listened to what they had to say. Staff were discreet when supporting people with personal care needs, and also when supporting people who had become upset.

We noted that some people had a 'My life story' booklet located in the care records. Some contained a lot of good quality detail, even photographs, but others were blank, missing or lacked sufficient detail. We asked the manager and staff about this. They told us the person's family was asked to either complete the booklet or spend time doing so with staff. Without a completed 'My life story' there was very little information in the care records about the person's background, career, hobbies and social interests. Although this was not consistently recorded for people, staff had a good knowledge about the background of each of the people living there. The manager said they would look at ways of completing these booklets in the absence of families doing so.

The care records included information about people's preferred routines; the times they liked to get up and go to bed, and their food preferences. We noted that each person's preferred gender of staff to provide support with personal care was not identified in the records. The manager said they would address this.

The care plans we looked at were individualised and included, where appropriate, quotes from people. For example, a person had a care plan for when they became upset. There was a quote from the person stating what it was that could lead them to becoming upset. This showed that people's input was taken into account when the plans were developed. The care plans were worded in a way that promoted people to be as independent as possible but with staff support if needed.

A keyworker system was in place. This meant each of the care staff was responsible for a small number of people, ensuring that their needs were met and they had sufficient toiletries and clothes. They also checked that each person's bedroom was kept clean and tidy.

The care records were stored in a cupboard on a ground floor corridor. On the first day of the inspection we noted that the lock was broken on the cupboard. The manager was aware of this and advised us it had been reported to the maintenance person. We also observed that the medication administration records had not been returned to the cupboard after they were used. We highlighted this to the manager and staff. The maintenance man fixed the lock. On the second day of the inspection all personal confidential information was locked away when not in use.

The manager was aware of local advocacy services and advised us that two of the people living at the home had advocates to represent them.

Good

Is the service responsive?

Our findings

People told us staff responded to any requests in a timely and pleasant way. They said they did not have to wait long. A person said, "It's smashing. They [staff] are very good. I'm so happy here." Throughout the inspection we observed staff responding to people's requests and needs in a way that was unhurried and individual to each person. For example, people ate their meal at their own pace and nobody was rushed. We observed a person continuing with their lunch long after all the other people had finished.

Families were pleased at how flexible and obliging the service was. A family member said to us, "They [staff] are so accommodating. If we get back late they will always keep a meal for [relative]." Another family member said that their relative used to attend church when they lived at home and staff had offered to continue with this activity.

Families told us that staff had a good understanding of how best to engage with their relative. A family member said about the staff, "They are more like friends. Mum has a wicked sense of humour and they really key into that." Another family member said to us, "The atmosphere is created by the staff therefore the residents are happy." Furthermore, a family member told us their relative had, "Thrived in this environment."

One of the people living at the home told us the staff had put on a "wonderful" party when they recently turned 90. The person invited approximately 50 family and friends and staff provided a buffet and entertainment. The manager put a memory book together for the person of their party. Staff also told us that they were planning a Halloween party for the people living at the home and their families, and friends.

The care records informed us that people's needs were assessed before they were offered a place at the home. This meant the staff had a good understanding of how to support the person and could plan to ensure the person's needs were met once they moved to the home. Families told us their views were sought when the care plans were being developed. A family member said to us, "I was very involved at the beginning but it [care plan] has not been reviewed yet". We could see that care plans were reviewed each month. Families confirmed that staff communicated well with them about any changes to their relative's care needs. We observed from the care records that families were contacted if, for example, their relative had a fall or the GP made a change to the medication.

People were supported to engage with activities they enjoyed and this included participating in household activities. A person told us, "I help clean the bathroom." We did see this person helping with the cleaning. The member of staff undertaking the cleaning said the person enjoyed helping with the dusting and cleaning more than the recreational activities available. They said, "The cleaning takes twice as long but I enjoy having that time with [person]." The member of staff also said, "We are a team with the residents. We all work together."

We asked another person about their day and they said, "More often than not I'm down in the kitchen." We enquired further about this and staff informed us that the person regularly helped out in the kitchen. They enjoyed this as it was linked to their previous career. The manager said the person did not mix much with the other people living there but had an excellent relationship with the chef and enjoyed working alongside her. A member of staff told us the person was a lot happier since helping in the kitchen and was smiling much more. Risk assessments had been completed to ensure the person was safe and the person had been provided with relevant health and safety awareness in a way that they understood.

We asked people how they spent their day. They all told us there was plenty going on if they wanted to join in. Some people said they just liked watching what was going on or having a chat with staff. One person said, "I read the paper or read books." A family member informed us activities were regularly available for people to participate in. They said, "[Relative] makes cards, paints, plays skittles and has sing songs."

An activity coordinator worked at the home and they organised activities within the home and arranged for people to go out on trips. People told us about a trip to the Safari Park and to the theatre in Southport. We observed various activities taking place throughout the inspection. We saw people having a foot message; both men and women. People were also painting and singing.

The activity coordinator said, "I will have a couple of activities going on at the same time as not everyone wants to do the same thing. On Fridays we decorate cakes and

Good

Is the service responsive?

play bingo. Thursday is our pampering day. We have hand massage, nail painting and foot massage. If the weather is nice we take the residents out for a walk." Some people liked to stay in their bedrooms and the activity coordinator said they made sure people in their bedrooms had one-to-one recreational time. We observed a tray of freshly baked cakes in the kitchen, which the chef said were for the people living there to decorate in the afternoon.

We looked at a feedback book that was in place to record people's input and views of the activities and the meals. In addition to previously identified activities, we could see from the book that reminiscence sessions took place. These included discussions about the war, families and past jobs. A summary of people's contribution was recorded and it seemed that people readily engaged in conversation about past events from their life. We observed the activity coordinator spending time with people on an individual basis asking whether they enjoyed their lunch.

The manager was trained in the 'Sonas approach'. This is a recognised multi-sensory way of supporting people living with dementia to express themselves. Sonas sessions provide cognitive, sensory and social stimulation. The manager explained that Sonas music sessions were held most afternoons. They were also held if people were upset as a session could have a calming effect. The manager told us that people enjoyed these sessions and engaged with the music through singing and foot tapping. The manager said they had plans to train other staff in the Sonas approach.

A complaints procedure was in place. The manager confirmed that no complaints had been received in the last 12 months. A large number of compliments, mainly in the form of thank you cards were made available to us and we could see that families were pleased with the care the home provided for their relatives. Families we spoke with were aware of how to make a complaint but assured us they had no complaints about the service.

We asked families how they were involved in providing feedback about the service. A family member said, "Through the resident's meetings". We noted from the minutes of the last meetings held in August 2015 that 16 family and friends attended. A feedback system was in place. The provider advised us that questionnaires were sent out to families twice a year.

Good

Is the service well-led?

Our findings

A registered manager was not in post as they had resigned from their position shortly before the inspection. The deputy manager had taken up the role of manager with the intention of applying to register with the Care Quality Commission (CQC) as manager.

We asked people living at the home their views about how the home was managed. People told us the manager was nice and one person said, "They [manager] are very good." Families too expressed their satisfaction with how the home was run. A family member said to us, "The manager is very accessible but the staff can also answer most things."

Families told us they had opportunities to provide feedback on the service through 'Residents meetings'. A meeting was held in August 2015 and it was well attended by families. The provider called the meeting because inaccurate rumours were circulating about the future of the home. Families were reassured and satisfied with the information they received at the meeting. This showed that the provider had dealt efficiently and swiftly with a situation that could have caused families to become upset.

The provider advised us that questionnaires were sent out twice a year seeking feedback on the service. We were provided with the outcome report for summer 2015, which followed analysis of the 22 questionnaires returned. The feedback was positive with the exception of one person who rated the food as poor. The provider advised us that negative feedback was followed up via a phone call if the person who returned the questionnaire left their contact details.

In addition, the staff we spoke with were positive about the leadership and management of the home. It was clear from our discussions and observations that they felt supported by management and that management led by example. Staff told us it was a good place to work as the staff team worked well together and supported each other. A member of staff said, "I feel very relaxed coming into work. The owners pop in and say hello to the residents and talk to the staff." Another member of staff said, "The manager is brilliant and very approachable. She helps out and works with you."

Staff told us an open and transparent culture was promoted within the home. They said they were aware of the whistle blowing process and would not hesitate to report any concerns or poor practice. A member of staff said the whistle blowing policy was outlined in the staff hand book and was available in the policy folder. They were confident the manager would be supportive and protective of them if they raised concerns. A member of staff said of management, "There is an open door if you have any questions."

We asked staff their views about the positive aspects of the service and what further improvements could be made. The feedback from staff included; good staffing levels, plenty of activities, staff routines not regimented, good team work and working well with families. Staff were unable to think of any suggestions as to how the service could be improved.

We enquired about the overall quality assurance system in place to monitor performance and to drive continuous improvement. The provider carried out a range of audits at the home. The audits included; care plans, health and safety, training, food, staff personnel records and medicines. The last two audits undertaken included checks of staff personnel records and a food audit. The provider advised us that they tasted the food as part of the audit.

The provider had not undertaken a recent medicines audit, which may account for why issues we identified with medicines had not been picked up by the service. By the second day of the inspection the manager had started to address the deficits with the medicines we had identified.

The care records were reviewed each month for each person living at the home. The key worker carried out the initial review and then the manager conducted a further review and checked that all documentation was up-to-date and reflected each person's needs. A range of up-to-date checks were in place in relation to the environment, equipment and cleaning.

A process was in place for recording, monitoring and analysing incidents. The majority of incidents we looked at related to falls. Body and face maps were used to highlight any injuries. A post falls checklist was in place to ensure that people were monitored for any adverse outcomes following the fall. The manager said they monitored the incidents for each person to see if there were any changes in patterns.

Good

Is the service well-led?

The manager ensured that CQC was notified appropriately about events that occurred at the home. Our records also confirmed this and included notifications for the people on an authorised DoLS plan.

A range of policies and procedures were in place and the provider advised that these were currently being reviewed. We were provided with the medicines policy as an example of a policy recently reviewed. Staff told us that they had access to the policies if they needed them.