Methodist Homes

Hall Grange

Inspection report

Shirley Church Road
Croydon
Surrey
CR9 5AL

Tel: 01332221942
Website: www.mha.org.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 10 and 12 January 2017, the first day was unannounced. At our last inspection in May 2014 the provider met the regulations we inspected.

Hall Grange is a 45 bedded purpose built home that provides residential care for older people. It is a new build property and accessible to people who use wheelchairs. Accommodation is provided on the ground and first floors with lounges and separate dining facilities on both floors and en suite bathrooms in all bedrooms. On the third floor there is a kitchen, large laundry room and staff office with passenger lift access to all floors. The ground floor consists of a central hub area, coffee shop and seating. There is also an activities room, hairdressing salon, administration and manager office. Some people use the service for respite care breaks. At the time of our inspection there were 40 people using the service.

There was a registered manager for the service. 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 using the service and their relatives told us they felt safe and well cared for at Hall Grange. Staff knew how to recognise and report any concerns they had about the care and welfare of people and how to protect them from abuse and harm. Where risks were identified, there was guidance on the ways to keep people safe. The service responded appropriately to allegations or suspicions of abuse.

The environment was safely maintained and people had the equipment they needed to meet their assessed needs. Individual bedrooms were personalised and furnished to comfortable standards.

The provider followed an appropriate recruitment process to check that staff were fit and suitable to work in a care setting. Staff received an induction and relevant training to support people with their care needs. This was followed by ongoing refresher training to update and develop their knowledge and skills.

The staff team had worked at Hall Grange for a number of years and knew people well. There were positive and caring relationships between staff and people who lived in the home and this extended to relatives and other visitors. Staff treated people who used the service and their guests with respect and courtesy. They were caring, patient and maintained people's privacy and dignity.

People's needs were assessed and planned for and staff had personalised information about how best to meet their individual needs. People's wishes, preferences and beliefs were reflected in their care plans. There was information about people's social relationships and they were encouraged to stay in touch with their families and receive visitors. Staff were responsive when people's support needs or circumstances changed and care records were updated appropriately.

People's care records recognised their rights and were person centred. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. When people were at risk of poor nutrition or dehydration, staff involved other professionals such as the GP or dietician.

Medicines were managed safely and people had their medicines at the times they needed them. Care plans contained information about the health and social care support people needed and they were involved in making decisions about their care. Arrangements were made for people to see their GP and other healthcare professionals when they became unwell or required additional services.

There was an open and inclusive atmosphere in the service and the registered manager led by example. Staff had a good understanding of the ethos of the home and were clear about their roles and responsibilities.

People and their relatives felt involved in the way the home was run and were encouraged to express their views and opinions. They knew how to complain and make suggestions, and were confident their views would be acted upon.

The provider had good oversight of everything that happened at Hall Grange. Management and staff completed regular audits to check the quality and safety of the service. Where improvements were needed or lessons learnt, action was taken.

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. People felt safe and staff knew about their responsibility to protect people from the risk of abuse and harm.

Individual risks to people's health and welfare were assessed and steps were taken to minimise these and keep people safe.

Staffing levels were sufficient to meet people's needs and the provider followed an appropriate recruitment process to employ suitable staff.

The environment was clean and maintenance took place when needed.

Medicines were managed safely and people received these as prescribed.

Is the service effective?

Good

The service was effective. People were supported by staff with the right experience and skills to meet their needs. There was an ongoing programme of training for staff to keep their knowledge and competence up to date.

Consent to care and treatment was sought in line with the Mental Capacity Act 2005 and staff understood the requirements of this to protect people's rights. Staff knew their responsibilities should a person be unable to make a decision independently or if someone was being deprived of their liberty.

People were given choice about what they wanted to eat and drink and were supported to stay healthy. Staff sought healthcare advice and support for people when required. Relevant professionals were involved where necessary.

The environment was designed and equipped to meet the needs of people using the service.

Is the service caring?

Good

The service was caring. People told us that staff were caring and supportive and always respected their privacy and dignity.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. Staff knew people well and had developed positive relationships with them.

Care plans were individual and included information about what was important to the person and their preferences for staff support.

Is the service responsive?

Good

The service was responsive. People's needs and preferences were assessed before they came to live at the service. Their care and support needs were monitored and reviewed and staff responded promptly when there were changes to people's health or wellbeing.

A programme of activities was available for people to take part in. People were supported to follow their individual interests and hobbies.

There were regular opportunities for people and those that mattered to them, to raise issues, concerns and compliments.

Is the service well-led?

Good

The service was well-led. People were positive about how the service was run. The registered manager showed effective leadership and encouraged people, relatives and staff to share their experiences of the service.

There was open communication between management and the staff team. Staff felt supported in their roles and in developing best practice.

A variety of audit systems were used to monitor and develop the quality of the service. Action was taken where needed to improve the care and support people received.

Hall Grange

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.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. Prior to our visit we also reviewed the information we held about the service. This included inspection history, any safeguarding or complaints and any notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law.

This inspection took place on 10 and 12 January 2017 and the first day was unannounced. The inspection was carried out by one inspector, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 16 people using the service, five visitors, the registered manager, deputy manager and seven members of staff, including the kitchen staff, activities co-ordinator and a domestic.

We reviewed care records for nine people who used the service. We checked four staff files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits and health and safety records. We also checked how medicines were managed and the records relating to this.

Following our inspection the manager provided us with information we had requested about staff training and quality assurance findings.

Good

Is the service safe?

Our findings

People told us they felt safe and "well looked after" by staff at Hall Grange. People were offered a key to lock their bedrooms and had a lockable drawer in their bedroom to store their valuables. Relatives we spoke with were confident that staff kept their family members safe.

Staff were clear about their role to protect people from the risk of abuse and completed safeguarding training every year to keep up to date with best practice. They knew their responsibilities to report any suspicion of abuse to the management team and outside agencies, such as the local authority. Contact numbers were displayed in the home that staff, people who used the service or visitors could use to report any concerns regarding abuse. The registered manager was aware of her role and responsibilities in raising and reporting any safeguarding concerns. Records held by the home and CQC showed the service had made appropriate safeguarding referrals when necessary and that staff worked in partnership with the local authority and other agencies to protect people.

People were protected from avoidable harm because risks to their health and welfare were identified and managed. Assessments had been carried out to assess the levels of risk to people in areas such as nutrition and hydration, falls and developing pressure sores. Where a risk was identified, there was clear guidance to help staff support them in a safe manner. Manual handling plans gave staff information about how to use equipment to support people safely when assisting them to mobilise. Risk assessments were periodically reviewed or in response to any changes or accidents. Staff understood the risks people faced and knew what action to take to minimise these.

Records of accidents and incidents we reviewed included an analysis of what had happened and any action taken to prevent reoccurrence. People's weight and falls were monitored and action had been taken to address any changes identified. For example, other agencies such as the falls intervention team or dietician became involved when needed.

Hall Grange was well maintained and the premises regularly checked to help ensure the safety of people, staff and visitors. Health and safety checks were routinely carried out in the building. Appointed contractors completed regular maintenance and servicing of fire, gas and electrical safety. Equipment was tested that it was safe for people to use. This included maintenance checks on wheelchair safety, the lift, hoists and adapted baths. The provider employed their own maintenance staff to carry out any essential repairs where necessary.

There were appropriate plans in place in case of an emergency or other event that required immediate action. For example, if there was a loss of electricity or a fire. People had up to date personal emergency evacuation plans (PEEPs). These outlined the support people required should they need to leave the building in the event of a fire or other emergency. Staff were trained in first aid and were able to contact management on call if there was an emergency out of hours.

The environment was clean and tidy. Dedicated staff were employed to clean the communal areas,

bedrooms and bathrooms. People confirmed that the domestic staff came in daily to clean their rooms. Anti-bacterial hand gel was available throughout the building. Protective clothing was available to staff and appropriate arrangements were in place for the safe storage and disposal of clinical waste.

The provider undertook the required recruitment checks before staff started work. Personnel records for three newly recruited staff members included a job application form, full employment history, interview notes, qualifications and training certificates, health declaration, proof of identity, check with the Disclosure and Barring Service (DBS) and two written references. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record. In some other staff files, we found that details of previous employment history and any gaps had not been explored. When we raised this with the registered manager they took action immediately and arranged for all staff files to be audited. Following our inspection the manager confirmed that she had arranged to meet with the identified staff to clarify and document the gaps.

Staffing levels were planned based on the number of people at the home and their level of dependency. The registered manager used an assessment tool to determine the staff hours required to meet people's needs. Staffing levels were monitored every month by the manager and adjusted when necessary. When we inspected, daytime staffing levels included a minimum of seven care staff with four carers available during the night. Ancillary staff were employed including laundry and domestic staff, a chef and activities co-ordinator.

People commented there were enough staff to support their needs although one person said "they could do with a few more staff leading up to mealtimes when it is busy." Relatives we spoke with felt staffing was sufficient and one told us that staff were "always around" when they visited. Some people preferred to spend time in their rooms and confirmed that staff often called in to check on them. People said staff responded promptly to any request for support and when they needed to use their calls bells or pendants. In the Hub area one person told us they had been pressing the call button for some time but no one had responded. When the person attempted to get up using a frame, we observed a member of staff came to assist. Several people chose to sit in the corner of the Hub and we observed that some people found it difficult to manoeuvre in or out with their walking frames. We discussed this with the registered manager who agreed to look at the seating arrangements and ensure staff monitored the situation.

People told us they received their medicines when they needed them. Some people told us they managed their medicines independently. We saw risk assessments in their records to support this. Individual profiles included details about the name of the medicine, the dose and how people liked to take their medicines. Some people were taking specialised medicines and guidance was available to staff to ensure these medicines were administered correctly. Medicines we checked for people corresponded with their medicine administration records (MARs). The records were up to date and there were no gaps in the signatures for administration. Prescribed topical creams (medicines which are applied to the skin) were recorded on MARs to ensure they were applied when needed. Where people were prescribed medicines 'as required' or only at certain times there were guidelines about the circumstances and frequency they should be given. People's prescribed medicines were reviewed by relevant healthcare professionals as necessary.

Only staff who had received training on safe administration of medicines did so. Their competency and practice was assessed every year to ensure that they continued to manage medicines safely. Regular checks and audits were carried out to make sure medicines had been given and recorded correctly. These included daily and weekly checks to identify and resolve any discrepancies.

Medicines, including controlled drugs, were securely stored in appropriate conditions in a clinical room.

Relevant temperatures were monitored and recorded daily to make sure that medicines were stored at the correct temperature. There was a system for checking all prescribed medicines and records for their receipt and disposal. Policies about medicines including covert administration were in place. (Covert is the term used when medicine is administered in a disguised way without the knowledge or consent of the person receiving it.)

Good

Is the service effective?

Our findings

People were confident they were supported by staff who were knowledgeable about their needs. They felt confident in the care provided by staff and several people commented that "they(staff) work jolly hard". One person who used a hoist confirmed there were always two carers to assist and told us, "They know my routine for getting me comfortable in bed at night." Another person told us that staff knew about their medical condition and what to look out for if they became unwell.

Staff were supported with training in order to keep up to date with best practice and extend their skills and knowledge in meeting people's needs. New staff completed an induction which involved shadowing another staff, depending on experience. The provider used the Care Certificate which is a nationally recognised framework for good practice in the induction of staff. Existing staff were due to complete a self-assessment to review their competencies against the expected standards.

The provider had a training and development programme of required learning. Topics included safeguarding, moving and handling, medicines, dignity and respect, equality and diversity, fire safety, infection control, food hygiene and first aid. Staff told us they were expected to refresh these key areas of training regularly. The registered manager used an electronic training record to monitor the training staff received and check they were up to date. The record included a red, amber or green rating for attendance. There was also a training plan for the next twelve months.

Staff told us they received the training they needed to care for people. This included dementia awareness, end of life care and practical training sessions on moving and handling so they knew how to move people safely and comfortably. Staff files we checked did not always contain evidence that staff had received specific training associated with some people's needs. For example, caring for a person with a Stroke condition. Following our visit the registered manager provided evidence that relevant training had been arranged for staff. This also showed there were plans for staff to attend refresher training in preventing pressure sores, catheter care management and diabetes over the next two months.

Staff received supervision and appraisal to discuss their performance. The registered manager kept a record to show who was responsible for supervising each member of staff. Supervision meetings were held every two months and provided staff and supervisors with the opportunity
to discuss professional development and training. Staff completed an end of year review that incorporated a personal training and development plan for the following year. Staff told us they felt well supported and could report any concerns to their supervisor or the registered manager.

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 confirmed that staff always sought their consent before care and support was provided. Throughout our inspection staff offered people choices and supported their decisions about what they wanted to do. People using the service and relatives, where appropriate, had signed in agreement with records about their care. Staff knew their responsibilities and what to do if a person could not make decisions about their care and treatment. This included involving people close to the person as well as other professionals such as an advocate or GP.

The registered manager and staff understood the legal framework that needed to be put in place if a person was being deprived of their liberty. At the time of our inspection, no-one using the service was subject to a DoLS authorisation. Policies and guidance were available to staff about the MCA and DoLS and all staff had received appropriate training to support their understanding. The manager had held a workshop on MCA and DoLS at a recent staff meeting which involved discussion and a knowledge check of the legislation.

We joined people in the dining rooms on each floor for lunch. The daily menu was displayed on a board and reflected a varied and nutritional diet. People told us they were asked each morning for their meal choices and offered an alternative if they didn't like the daily options. During our first visit, one person told us they had not been asked and a staff member promptly made sure the person received their meal choice. We saw information was available to staff about each individual's preferences for food and drink, including how they liked their tea or coffee and preferred breakfast.

People shared mixed views about the food and some said they had noticed a difference since the chef had recently left. One person told us, "It can vary now in how good it is" and another person said, "The quality of the food has gone down." The registered manager was addressing this and in the process of recruiting a replacement cook at the time of our inspection. During our first visit, one of the candidate chefs prepared a sample of meals and some people took part in a food tasting session so they could provide feedback about the quality.

We found the dining experience was tailored according to people's preferences. For example in one dining room, background music was playing and in the other, people told us they preferred a quieter environment. Staff were available to support individuals where needed. People were asked if they wanted further helpings and were offered a choice of desserts. One person told us, "(name of staff) likes to make sure everyone is fed and watered." A number of people commented that they would prefer they all ate in the same dining room, so they could meet with friends from the other floor. The registered manager was aware of this and told us they had plans to make use of a larger dining area on the third floor.

Care plans included details about people's nutritional needs as well as their favourite foods and specific diets. People were assessed for the risk of poor nutrition and hydration and staff used the Malnutrition Universal Screening Tool (MUST) to do this. Monitoring sheets were in place for those people at risk and were reviewed monthly. We saw that where required, records were kept of people's weights, food and drink intake and positional changes to prevent pressure sores. Staff told us they would contact the GP if they noted any significant changes. Other professionals, such as the dietician, were involved in people's care if this met an identified need. A care plan we reviewed showed that one person had been at risk of malnutrition in the past. Charts showed this person's dietary intake had been monitored and their weight had been checked on a regular basis.

People had access to healthcare services and received ongoing healthcare support. A variety of healthcare professionals visited the service to provide advice and care for people when needed. Care records contained evidence of visits from and appointments with district nurses, the mental health team, opticians, speech and language therapist and dietician. People had seen other specialists where appropriate and staff followed any advice provided by professionals. Where people had specific health care needs this was recorded in their assessment and care/support plan. There was information available alongside the care plan which explained more about the condition and how to support someone with it.

There were accessible toilets and bathrooms situated throughout the building. Facilities were equipped with sufficient aids and adaptations to meet people's physical needs such as raised toilet seats and hand rails for support. People had mobility aids and other specialist equipment to promote their independence and there was passenger lift access to the upper floors. Bedrooms were spacious with accessible en suite shower and toilet facilities.

Areas of the home promoted engagement and wellbeing for people living with dementia. In the corridors, there were pictures that provided people with stimulation or links to past memories, landmarks and activities. Picture signs enabled people to orientate and there were sensory items, including different types of materials for people to touch and feel.

Good

Is the service caring?

Our findings

People felt well cared for, they spoke positively about the staff and the quality of the care they received. One person told us they enjoyed having a chat with staff and another person said staff were always "very nice" if they had to call someone in the night. Other comments included, "You definitely get individual care", "the staff are very good" and "I can't thank (name of key worker) enough." One person described the staff as "very helpful" and another person said staff were "amazing." Relatives were also complimentary about the caring nature of the staff. A relative said they "were made to feel very welcome" and that staff had made their family member "feel very special" when they moved in to Hall Grange.

Interactions between staff and people were positive and caring. Throughout our visit staff supported people with kindness and compassion. Their approach to people was respectful and patient. We observed staff members speaking clearly and kindly with people and taking time to sit with them for a chat or accompany them with walking. Many of the staff had worked at the home for several years and knew people well. They were able to explain people's individual likes and preferences in relation to the way they were supported. This information corresponded with what people told us and their care records.

People were encouraged to maintain links with people who were important to them. One person told us that the staff had set up Skype for them to keep in touch with a relative who was living abroad. During a period of respite care one relative said the staff had kept the family, who were out of the country, well informed about their family member.

People and visitors we spoke with confirmed that they were always made to feel welcome at Hall Grange and could speak to the staff or manager at any time. Relatives told us staff kept them informed about people's welfare and they were involved in reviews and other meetings as appropriate.

People said they were included in decisions concerning their care. For example, they decided the times they got up and went to bed; how and where they spent their day and what activities they participated in. One person told us, "The staff do involve me." People were also given information about the standard of care to expect and the services and facilities provided by the home. When people first moved in, they were asked about preferred daily routines and what level of assistance they required. We saw information about personal preferences, likes and dislikes, what helped them relax, kept them happy and things that were important to them. One example included, "things that make me laugh- small children and animals."

Care plans included background information about people's lives prior to living at Hall Grange. People told us that staff had time to chat and get them to know them as individuals. This included finding out about their families, their previous careers or home life, and where they had travelled to. Relatives were also asked for details their family members' personal histories and interests.

People were encouraged to maintain their independence and skills. Staff told us that they recognised the importance of encouraging people to do things for themselves and that this was promoted when possible. For example we saw people were encouraged to mobilise with their walking frames and to eat

independently.

People told us staff treated them with respect and dignity and we observed this practice throughout our inspection. We observed staff always knocked on people's bedroom doors and waited to be invited in. People confirmed that staff always asked for their permission before a care task was carried out. There were quiet areas throughout the home where people and their visitors could meet in private. People received personal care in the privacy of their bedroom or bathroom with doors closed. Bedrooms we saw were personalised and furnished with pictures, photos and other items of sentimental value. Where people chose to have their door open or closed, their privacy was respected.

People's private and personal information was stored securely and staff spoke in confidence about people's care needs. Staff had received training on the principles of privacy and dignity and person centred care.

Care records showed that people had discussed their wishes about how they wanted to be cared for at the end of their lives. Staff were in the process of undertaking end of life care training. This was facilitated by the local hospice team, who also provided advice and support to the home about end of life care.

Good

Is the service responsive?

Our findings

People and their relatives felt the service was responsive and staff were flexible in meeting their needs. One person and their visitor told us they were "very happy with the care." Another person told us, "There is nothing I would change" and that there was "nothing to worry about."

Assessments took place before people moved to Hall Grange to determine if the service could meet their care needs and expectations. A relative confirmed they visited before their family member had moved and their first impressions had been "very favourable." They had been asked to share information about their family member's likes and dislikes and said the transition had been "seamless" and "everything was thought of."

We reviewed an assessment for the person who had moved in most recently. The assessment considered all aspects of the person's life, including their background, hobbies, social needs, preferences, past medical history, health and personal care needs and areas of independence. It included details of specific care areas such as nutrition, skin care and mobility.

People's diverse needs were understood and supported and they were asked about their preferences as part of the admission process. Care plans included details about people's needs in relation to age, disability, gender, race, religion and belief. People told us how important their faith was to them. Prayer services were part of the daily activities; most people in the home were members of the Methodist Church and had chosen the home based on its religious ethos.

Information from the assessments were used to develop care plans based on the person's needs. These plans were kept in a folder in people's rooms and explained the support people required for their physical, emotional and social well-being. There was information about what a person could do for themselves and what support they required from staff. Plans were personalised and kept up to date. Care records reflected how specific health conditions might impact upon people's care and how this affected their daily lives. For example, guidelines about diabetes or management of pressure sores were available to support staff to provide appropriate care. Short term care plans were written when people developed an acute condition such as a urinary infection.

Records showed people's needs and abilities were reviewed every month and their care plans were updated when their needs changed, for example after a return from hospital. Staff made appropriate referrals on behalf of people who used the service when needed. For example, the service sought the support of healthcare professionals such as the falls intervention team, district nursing service and GP. Records confirmed that instructions made by other health care professionals had been carried out. We saw that people's placements were reviewed regularly. Review meetings took account of health, social and emotional changes and involved people's family, care managers and other representatives.

The staff had knowledge about how each person liked to receive their personal care and what activities they enjoyed. They were able to tell us what they would do if people were unwell, unhappy or if there was a

change in a person's behaviour. These details were included in the care plans. Staff completed daily plans and shared information at each shift change to keep up to date with any changes concerning people's care and support. We observed staff regularly checked on people who were in their own rooms. On one occasion a member of staff alerted the senior in charge that a person appeared unwell and both staff returned to make sure the person was comfortable and free of pain. We spoke with this person who told us staff were "excellent" and often called in to check on them as they were recovering from a chest infection.

People had a range of activities they could be involved in, which were planned according to people's preferences and requests. People told us there was a good choice and they enjoyed visits from outside entertainers. There were also volunteers to support people in the home and the local community. One person told us, "There is always something to choose to do". Everyone we spoke with appreciated the garden. Some people said that it was particularly good in the summer when they found they got to socialise more with people from "the other floor" who they didn't usually see at mealtimes. A relative said their family member "thoroughly enjoys participating in all the activities on offer."

Written information about the weekly activity timetable was advertised around the home. There were notice boards which showed forthcoming events and photographs of people at Hall Grange enjoying the activities they took part in. During the two days we saw a range of activities taking place and the activities co-ordinator was energetic and busy engaging with people. We observed people playing quoits, taking part in mobility exercises, colouring and a discussion about current affairs. There was a separate activities room for people to use and on site hairdressing salon. The activities co-ordinator recognised the importance of social interaction for people and involved them in planning activities. Particular favourites included arts and crafts, competitive games such as carpet bowls or quoits, quizzes and pampering sessions such as manicures.

In addition to group activities people were able to maintain hobbies and interests, staff provided support as required. One person enjoyed an art club and another person told us their key worker regularly accompanied them to football matches, describing the member of staff as "wonderful." Another person explained they liked to spend more time in her room due to a medical problem. They said the activities staff often visited to do their nails and that they enjoyed the church services.

People and relatives we spoke with told us they were encouraged to give feedback about the service through care plan reviews, meetings and annual surveys. People felt confident and comfortable with expressing their opinions if they needed to and welcomed the monthly meeting for this purpose. People spoke openly about what they liked and didn't like and were encouraged to influence change. Examples where suggested changes had been made included the provision of sauce sachets instead of bottles at mealtimes, improvements with food and a change of catering staff.

People told us they knew how to make complaints about the service and were confident any issues would be addressed. People said they would speak to the manager or senior staff. One person said they would speak to a member of their family first and let them deal with it. Two people said they had never had cause to complain but welcomed the monthly meetings where they felt confident to speak up. One person told us they had raised a concern in the past and this was dealt with.

Information about how to make a complaint was displayed and a comments/suggestions box was available to people in the entrance area. The procedure included details about other relevant organisations if someone wished to raise a concern outside of the home. The manager kept a record of complaints and concerns and how these were managed. This showed the nature of the complaint, action taken and how it was resolved and fed back to the person, including a written response. For example, a verbal complaint had been raised about the loud tone of a call bell and this was promptly adjusted. The registered manager told

us standards of laundry had been a theme for complaints. The home had acted on this and improved the arrangements for washing and labelling people's clothes.

Good

Is the service well-led?

Our findings

There had been a change in leadership since the last inspection. People and their relatives were complimentary about the registered manager who had been working in the service for over a year. One person told us, "The management is very good and the place is well run." Another person said the home was "well managed and I see (the registered manager) regularly." Another person told us the manager knew them well and said, "She is very friendly and approachable." People told us they welcomed the monthly meetings where they can give their opinions and confirmed that the manager or deputy always attended.

There was a positive culture in the service. Interactions between people, their relatives and visitors, the staff and management were friendly and welcoming. Throughout our visit, the registered manager was supportive, friendly and led by example. She had good knowledge of all the people who used the service and offered support and guidance to staff.

Staff had clear lines of accountability for their role and responsibilities and the service had an effective management structure in place. The registered manager was supported by a deputy manager who had worked in the service for many years. Staff we spoke with felt supported by the management team and each other. One staff member told us, "There is good teamwork" and another member of staff explained how they were able to have an improved work life balance following an adjustment to their role. The provider had a reward scheme recognising employees for achievements in the workplace. Each month, people using the service were able to nominate two members of staff when it was felt they had gone the 'extra mile' in their work. Staff told us there was also an employee of the month award and one staff member said they had been recognised for five years service at the home.

The registered provider had clear values about the way care and support should be provided. These values were based on providing a person centred service that supported people to maximise their independence and uphold their dignity. Staff were aware of these values and management monitored they followed them in practice. For example, at a residents meeting the registered manager checked with people that staff always knocked on their bedroom doors to which they all agreed.

We found the service promoted and encouraged open communication. Daily handovers took place so that staff were kept up to date with any changes to people's care and welfare. Staff meetings were held every two months and included discussions around the care provided and any matters that affected the service, including issues staff wanted to raise. The handovers and meetings were used to reflect on standard practice and evaluate current procedures. For example, the care plan system, daily monitoring records and call bell responses had been improved following review. Meetings were also used to share learning and best practice. We saw how the manager and staff had discussed effective hand hygiene procedures and key principles about MCA and DoLS to refresh their knowledge.

The provider sent questionnaires to people, relatives, staff and stake holders in the service to ascertain their views. The survey asked people and their family members/representatives to rate and comment on aspects of the service. This included views about the staff, people's daily care, choice, quality of life and cleanliness

and comfort. The most recent survey was sent out in November 2016 and responses were still being reviewed at the time of our inspection. Results from the previous year showed that people were happy with the care and support they received. The few suggestions for improvement had been actioned. 'Continuous improvement' forms were also available for people and relatives to feedback their experiences at any time. In the last twelve months there had been 39 complimentary letters about the service from people and relatives.

Prior to our inspection, the registered manager completed a Provider Information Return (PIR) and returned it to us within the agreed timescale. The PIR gave us good information about how the service performed and what improvements had taken place or were planned.

Quality assurance systems, developed by the provider, were in place to formally assess and monitor the quality and safety of the service. These were undertaken by staff, management and the provider's quality assurance team. An assessor visited every three months to check how the service was performing. Their report identified where improvements were needed with a red, amber or green rating for compliance. We saw the current action plan was detailed, progress was kept under review and actions were monitored until completion. Priority actions with a red rating had been addressed and other actions were underway.

The registered manager completed a monthly audit which included data about falls, nutrition, skin integrity, hospital transfers, safeguarding and DoLS events, staffing levels, medicines, care plans and complaints. She also reviewed any incident/ accident reports and audit information was shared with a service manager every month. This enabled the service to identify any patterns or trends and recognise where people's general health and mobility was improving or deteriorating. Where they identified any concerns, they took action to minimise the risks of a re-occurrence. For example, when a person lost weight or sustained a pressure sore, appropriate professionals were involved. In addition, people's care plans and risk assessments were updated.

Other in-house audits were regularly carried out by the staff team who each had designated responsibilities. There were ongoing checks on health and safety practice, safety and presentation of the environment, infection control and laundry audits. Records were clearly maintained and showed what action was being taken in response to any shortfalls. The provider used learning from audits to make changes and improvements in the service.

The manager and staff worked in partnership with other professionals to help ensure people received the most appropriate support to meet their needs. Care records showed how the service engaged with other healthcare agencies and specialists to respond to people's care needs and to maintain people's safety and welfare. During our inspection, the registered manager welcomed any guidance we gave and they also took prompt action to address the few issues we identified during the inspection.

Registered persons are required by law to notify CQC of certain changes, events or incidents that affect a person's care and welfare. For example, when a death or injury to a person occurred. Before our inspection we checked the records we held about the service. We found that the manager had notified us appropriately of any reportable events and provided additional information promptly when requested.