Gainford Care Homes Limited

Lindisfarne Hartlepool

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 27 and 31 July 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Lindisfarne Hartlepool provides care and accommodation for up to 54 people, some of whom have a dementia type illness. On the day of our inspection there were 51 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

Lindisfarne Hartlepool was last inspected by CQC on 28 June 2016 and was rated Requires improvement overall. No breaches of Regulations were identified at the previous inspection, however, actions were required to improve the service.

Accidents and incidents were appropriately recorded and analysed monthly to identify any trends. Risk assessments were in place for people who used the service and described potential risks and the safeguards in place to mitigate these risks.

At the previous inspection it was identified that not all safeguarding records were complete. At this inspection we found records had been appropriately completed, the manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

The home was clean, spacious and suitable for the people who used the service, and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff. Staff were suitably trained and training was arranged for any due or overdue refresher training. Staff received regular supervisions and appraisals.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA) and was following legal requirements in respect of the Deprivation of Liberty Safeguards (DoLS).

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care

specialists.

People who used the service and family members were complimentary about the standard of care at Lindisfarne Hartlepool. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

People's needs were assessed before they started using the service and an admission checklist was completed. At the previous inspection some inconsistencies were identified in people's care records. At this inspection we found care records were accurately completed, up to date, and regularly reviewed and evaluated. Care plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs, and the service had good links with the local community.

People who used the service and family members were aware of how to make a complaint however did not have any complaints to make.

At the previous inspection it was identified that the quality assurance process was, "work in progress". At this inspection we found the provider had an effective quality assurance process in place. Staff said they felt supported by the manager and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys. Family members told us the management were approachable and visible.

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.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated and risk assessments were in place for people and staff.

The manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported with their dietary needs.

People had access to healthcare services and received ongoing healthcare support.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service and care plans were written in a person centred way.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the manager was approachable and they felt supported in their role.

The service had good links with the local community.

Lindisfarne Hartlepool

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 and 31 July 2017 and was unannounced. This meant the staff and provider did not know we would be visiting. One adult social care inspector and an expert by experience formed the inspection team. 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 we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff.

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. We used this information to inform our inspection.

During our inspection we spoke with nine people who used the service, seven family members and a healthcare professional. We also spoke with the registered manager, regional manager, activities coordinator and three members of staff.

We looked at the care records of four people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

We carried out observations of staff and their interactions with people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand

the experience of people who may not be able to talk with us.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Lindisfarne Hartlepool. They told us, "Yes, I am [safe]. The staff are very vigilant", "Yes, I do feel safe. The staff are very caring and pleasant", "Very much so, the security is good and the staff are always around" and "Oh yes I do [feel safe], there's always plenty of staff on hand and they always engage with people." Family members told us, "Oh yes definitely, she is very safe in this home", "My [relative] has been in the home for five years and I've always felt that she was safe" and "I feel that my [relative]is in good hands."

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff, and on an ongoing basis as necessary.

We discussed staffing levels with the manager and looked at staff rotas. Staffing levels were determined by a dependency tool which incorporated the needs of each person who used the service. The manager told us that whenever they had asked for staffing levels to be increased, the provider had supported their decision. The manager told us they did not use agency staff at the home. Absences were covered by their own permanent staff or bank staff, and if required, the manager or deputy manager would cover shifts.

A visiting family member brought to our attention that they had been waiting 15 minutes for a member of staff to assist their relative. We brought this to the attention of the manager who immediately saw the person's needs were attended to. This occurred at lunch time when staff were busy assisting people in the dining room and was the only negative feedback we received about staffing levels and response times during the two days of our inspection visit. People and their family members told us, "There seems to be plenty of staff around from what I can see", "I'm quite satisfied with the amount of staff in the home", "Yes, there appears to be plenty around and I haven't had to press the call button yet", "During the day there seems to be quite a lot about, I've used my buzzer sometimes at night and you wait if they are busy" and "Yes, definitely I think so. I pressed my call bell yesterday morning so staff could unhook my oxygen bottle and they were there within two minutes."

The manager told us as part of their auditing processes, they went into people's bedrooms and pressed the call alarm to gauge the response times of staff. Any issues were discussed in meetings and in staff supervisions. Our observations were that call bells were answered in a timely manner and there were sufficient numbers of staff on duty to meet the needs of the people who used the service.

The home is a three storey building. Entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, spacious and suitable for the people who used the service. The home had a number of infection control policies in place that included assessing and reducing risk, illness in the home, and cleaning. Infection control audits were carried out monthly and the home had infection control champions. We saw the infection control champions had attended study days and were in regular contact with the local infection control nurses. Staff were trained in the control of substances hazardous to health (COSHH). Appropriate personal protective equipment (PPE), hand hygiene signs and liquid soap were in place and available. People and family members we spoke with were complimentary about the home. They told us, "It's always spotless and very clean", "It's champion, it's always very clean" and "It's really great, it's very clean and smells fresh and clean. It's fantastic compared to the other couple of homes she has been in."

Accidents and incidents were appropriately recorded and analysed monthly to identify any trends. Actions were put in place for any identified issues. For example, any person who had a fall was referred to the local falls team.

Risk assessments were in place for people who used the service and described potential risks and the safeguards in place. The manager completed a 'Risk monitoring report' on a weekly basis. This included details of any people with pressure damage, serious changes in health, weight variance, infection control, complaints about care, safeguarding alerts, and any serious accidents/incidents. Policies and procedures were also in place to protect staff. For example, manual handling, first aid at work, the use of work equipment and PPE, and lone working. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Regular maintenance and health and safety checks were carried out, including checks of the fire alarm and firefighting equipment. Fire drills took place regularly and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. Equipment was in place to meet people's needs including hoists, pressure mattresses and wheelchairs. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

At the previous inspection it was identified that not all safeguarding records were complete. At this inspection we saw a copy of the provider's safeguarding policy, which provided definitions of an adult at risk, the nature of abuse, the responsibilities of staff, training requirements, and action to take. A log record was in place for any safeguarding related incidents. Records included details of the alleged victim, alleged perpetrator, action taken and the outcome. We found incidents had been appropriately alerted to the local authority and CQC was notified of any relevant incidents. The manager understood their responsibility with regard to safeguarding and staff received training in the protection of vulnerable adults. We found the provider understood safeguarding procedures and had followed them.

We looked at the management of medicines at the home. Medication audits were carried out monthly and staff competency checks were carried out twice yearly. Medicines were stored in locked trolleys in the treatment room. The temperatures of the treatment room and refrigerator were recorded daily to ensure medicines were stored at the correct temperature.

Medication administration records (MAR) included a photograph of the person, and a record of any medical conditions and allergies. A MAR is a document showing the medicines a person has been prescribed and

records whether they have been administered or not, and if not, the reasons for non-administration. MARs we saw were accurate and up to date. A healthcare professional told us, "They've [staff] have got a good understanding or what needs to be done [with regard to medicines]" and "The girls are proactive in making sure things are right." This meant appropriate arrangements were in place for the safe administration and storage of medicines.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. People and family members told us, "I think they are [well trained staff] because they are very caring and the home is not posh but very homely", "I think the staff are very good and a couple are excellent", "Yes, I do [think staff are well trained]. They seem to know what they are doing" and "Yes, they really got to know my [relative]'s needs straightaway."

Staff received mandatory training that included mental capacity, fire safety, moving and handling, falls prevention, dementia, equality and diversity, food safety, health and safety, COSHH, nutrition awareness, conflict resolution, basic life support, safeguarding, end of life and infection control. Mandatory training is training that the provider deems necessary to support people safely. Additional training was provided as necessary. For example, the manager told us eight staff had completed the 'Dementia friends' training and the remainder of the staff were being signed up for it. All staff were also enrolled on a recognised qualification in health and social care. The manager monitored compliance with staff training via the provider's training matrix and records we saw were up to date.

New staff completed an induction to the service and all new staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Staff received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor. Supervisions at the service included a review of performance, agreed future work targets, personal development and training needs, and policies and procedures.

People were supported with their dietary needs. 'Diet notification forms' were completed for people and included details of any allergies, special dietary requirements, food and drink likes and dislikes, and whether any assistance was required at mealtimes. A copy of this information was kept in the kitchen. One person had been identified as having difficulty swallowing. Their care plan described how they required a fork mashable diet and full support from staff at meal times. The person had been referred to a speech and language therapist (SALT) and their guidance was included in the person's care plan. A choking risk assessment and a Malnutrition Universal Screening Tool (MUST) had been completed. MUST is a tool used to identify whether people are at risk of malnutrition and included a record of the person's weight, body mass index score and level of risk. Records were regularly reviewed and up to date.

We observed the lunch time experience on two floors and saw there were two sittings. The first sitting was so that people who needed additional support could receive one to one support from staff. We observed staff supporting people in a calm, unhurried manner and communicated with people to let them know what they were doing. People were offered choices and asked if they wanted another drink or were ready for a dessert. Staff wore appropriate personal protective equipment and people were offered aprons to protect their clothing if they wanted them.

People and family members were very positive about the food at the home. They told us, "I don't need any help to eat but I've seen staff help others, the food is usually good and we have a good choice", "My wife gets her meals in her room and I have lunch at least three times a week in the dining room and the food is first class" and "I do enjoy the meals here and I always get a good choice."

People had communication care plans in place that described people's ability to communicate and make their wishes known. One person's care plan stated they were hard of hearing so wanted staff to speak to them in a louder tone. The person also needed to be facing staff when communicating, in order to see who they were speaking with and to improve communication.

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. Mental capacity assessments had been completed for people and best interest decisions made for their care and treatment where applicable. The manager maintained a register of DoLS applications that had been submitted to the local authority and when they had been authorised, and statutory notifications for any authorisations had been submitted to CQC.

Care records included signed consent forms. For example, for care records, medication records, wounds/injuries and social activities. Care plan agreement forms were also completed by people who used the service, or family members if the person was not able to make the decision.

Some of the people who used the service had 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms in place. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Forms we saw were up to date and showed the person who used the service, family members and healthcare professionals had been involved in the decision making process.

Emergency healthcare plans were also in place for people. These provided important information for hospital staff including, GP contact details, diagnosis, whether a DNACPR was in place, and whether the person wanted to be cared for in the home or in hospital.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GPs, district nurses, occupational therapists and chiropodists.

Some of the people who used the service were living with dementia. We looked at the design of the home for people with dementia and found corridors were wide, clear from obstructions and well lit. Handrails were painted a different colour to the walls, communal bathrooms and toilet doors were painted in a different colour to bedroom doors and were clearly signed. Corridors were themed and there was visual stimulation

and tactile displays for people to touch. Corridor themes included pet lane, memory lane and the seaside. Some of the bedrooms had memory boxes outside the bedroom doors where people had placed photographs, flowers and other things that were important to them. This meant the service incorporated environmental aspects that were dementia friendly.

Good

Is the service caring?

Our findings

People who used the service and family members were complimentary about the standard of care at Lindisfarne Hartlepool. They told us, "I think they are very caring in the home", "I honestly think they are very good looking after my [relative]", "Very, very caring, I couldn't wish for better and sometimes they go the extra mile by tidying my [relative]'s hair" "Oh yes, they are very caring, they are always there for you if you are not well" and "It's just the way they are with you, they are always there for you."

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. We saw and heard how people had a good rapport with staff. For example we heard staff asking people if they would like a drink and one of the people responded by saying, "You make the best tea in the joint."

Care records described how staff were to respect people's privacy and dignity. For example, "Privacy, dignity, respect and independence to be maintained at all times", "Staff need to respect [name]'s privacy and dignity at all times" and "[Name] is a cheerful man who wishes to maintain his dignity and independence at all times." The home had a dignity champion notice board, which included information provided by the National Dignity Council, and other information collated by the home's dignity champions. The dignity champions were members of staff who monitored dignity in the home and reported to the manager.

We saw staff knocking before entering people's rooms, and closing bedroom and bathroom doors before delivering personal care. We asked people and family members whether staff respected the privacy and dignity of people who used the service. They told us, "Very much so, the door is always closed for personal care and you do have a choice of carer if you request it", "If my [relative] needs the toilet they close the door, they have always been very respectful towards my [relative]", "If I close the door for a bit of quiet time, they don't bother me but they always knock before entering my room", "Indeed they do when changing my [relative], they close the curtains and the door and ask me to leave nicely" and "If I want the door shut for my privacy they do it for me because I can't walk." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

The manager told us, and we saw a notice that said, staff were taking part in 'Experiential training' at the home that involved spending meal times with people to experience for themselves what the meal time experience was like for people. A notice had been posted on the notice board to inform family members that this was taking place and not to approach the staff during this training.

Care records described what people could do for themselves and what they needed staff to support them with. For example, "[Name] can choose his own clothing but will require support to dress accordingly", "[Name] will mobilise independently without a staff member" and "[Name] requires support of one carer with hygiene needs." We observed people being supported to be independent as they mobilised around the home and people were encouraged to be independent at lunch time. People we spoke with told us they

were supported to be independent. This meant people were encouraged to care for themselves where possible.

Bedrooms were individualised, some with people's own furniture and personal possessions. We saw many photographs of relatives and social occasions in people's bedrooms. All the people we spoke with told us they could have visitors whenever they wished. Feedback we received from family members was that they could visit at any time and were always made welcome.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The manager told us none of the people using the service at the time of our inspection visit had independent advocates but information was made available if required.

None of the people using the service at the time of our inspection visit were receiving end of life care. However, advance care plans were in place for some people which provided information on what people wanted. For example, their preferred place of care, funeral arrangements, and who they wanted contacting. The provider's 'End of life care' policy set out the procedure for advance care planning and explained that not everyone was willing to be involved in such planning, so staff would encourage but not require people to participate in discussions about their end of life wishes.

Good

Is the service responsive?

Our findings

People's needs were assessed before they started using the service and an admission checklist was completed. At the previous inspection some inconsistencies were identified in people's care records. At this inspection we found care records were accurately completed, up to date, and regularly reviewed and evaluated.

People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. Each person's care record included a 'This is me' information leaflet that provided important information about the person. For example, the name the person liked to be known by, what they wanted staff to know about them, family information, life history, hobbies and interests, and a summary of their care needs.

Dependency profiles were completed for people to gauge their level of dependency. For example, with mobility, communication, personal care, feeding, pain, memory and continence. People's dependency scores were reviewed regularly and any changes were reflected in the person's care plans.

Care plans were in place for people and included mobility, nutrition and hydration, medication, communication, personal hygiene and dressing needs, skin integrity, continence, sleep and night care, emotional and social wellbeing, and use of the staff call bell. Each care plan included details of the person's individual needs, the objective of the care plan, actions to be taken and a record of the care plan evaluation. Risk assessments were in place where appropriate.

For example, one person was identified as being at high risk of falls. The person's care plan described how the person needed the support of two care staff and a walking frame to mobilise. Staff were advised to monitor the person as they would mobilise independently, increasing the risk of falls. Staff were instructed to maintain a safe environment for the person at all times and ensure they had their staff call bell to hand. The person also had a bed sensor in place as they often got up to use the toilet during the night. A falls risk assessment tool and a manual handling risk assessment had been completed. Both were regularly reviewed and the care plan evaluation was up to date. Where necessary, people had been referred to the local falls prevention team and their guidance was included in the care records.

Another person was identified as being at risk of pressure damage. The person's 'Skin integrity' care plan described how the person was supported in bed with regular positional changes, district nurse interventions and the application of barrier creams to reduce the risk of pressure sores. Their care plan evaluation, pressure ulcer risk assessment and records of positional changes were up to date.

Daily progress notes were up to date and included information on sleep patterns, diet and nutrition, activities, and personal care.

People's hobbies and interests were documented in their care records and 'Social well-being' care plans recorded what activities people enjoyed. One person was identified as being at risk from social isolation.

The person's care plan described how staff were to involve the person in activities. For example, "Offer [name] the chance to join in with the home's daily activities" and "Staff to involve [name] and encourage [person] to socialise with other residents." The care plan evaluation described how the person had occasionally joined in with activities and enjoyed gardening.

The home employed two activities coordinators and had a dedicated activities room. We saw people had been involved in arts and crafts, and paintings created by people were on the walls of the room and in the corridor. We asked people and family members if there was much to do at the home. They told us, "Lots to do, I bring my dog in every day to see my [relative]and everybody else is encouraged to get involved", "There's always plenty going on at the home and I bring the dog in for petting sessions and they all love him", "I was doing exercises the other week and managed to touch my toes", "My [relative] plays dominoes, cards and loves watching old movies and the staff encourage him to take part" and "I do paintings and art craft, those two pictures on the wall are mine and I made a vase which is in the communal room." We found the provider protected people from social isolation.

We saw there had been a number of positive compliments received by the home, which were displayed on the notice board. Comments included, "Just to say a very big thank you for all the care you gave our dearly loved brother", "We appreciate all you did to make mam feel part of the Lindisfarne family" and "Thanks again for all your care over the last years."

The provider had a complaints policy and procedure in place that was displayed on the home's notice board. The policy stated all complaints would be acknowledged within three working days, and investigations would be carried out and a written response provided within 28 working days. Contact details for CQC were provided should the complainant remain dissatisfied. There had only been two complaints recorded at the service in the previous 12 months. Each complaint record included details of the complaint and complainant, evidence gathered in response to the complaint, and copies or responses provided to complainants. People and family members we spoke with were aware of how to make a complaint but did not have any complaints to make. This showed the provider had an effective complaints policy and procedure in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months. The manager told us they worked closely with visiting health and social care professionals and implemented their recommendations and advice. For example, a recent local authority visit had made some recommendations regarding the activities room and the manager had implemented the recommendations.

The manager told us they regularly asked for feedback from visitors, for example, whether there was an odour in the home and whether it was clean. The manager told us they had plans to improve the garden and were piloting a new system where information could be sent electronically to the local community nursing team if someone wasn't well. The regional manager told us they were looking at introducing an electronic medicines recording system in the near future.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring people's personal information could only be viewed by those who were authorised to look at records.

The service had a positive culture that was person centred and inclusive. People who used the service, and their family members, told us, "Very approachable, both [manager and deputy manager]", "Yes, you can go and see her [manager] anytime you want to", "Very much so, her [manager] door is always open", "She [manager] is very friendly and she is always walking around" and "[Manager] is always around and she is very friendly, she even helps the staff."

Staff we spoke with felt supported by the manager. They told us, "We receive plenty of support", "If she's [manager] not here, we can just ring her" and "I love it. There's a really good atmosphere." Staff were regularly consulted and kept up to date with information about the home and the provider. Staff meetings took place every three months and a meeting was taking place on the first day of our inspection visit. Regular 'Flash meetings' were held between the manager and senior staff. These were meetings where the manager received an update from senior staff in each department of the home and could pass important information on. The manager told us about the employee of the month award that people, visitors and staff could recommend a member of staff for. We saw information on this was on the wall outside the manager's office, including a photograph of the most recent winner.

The service had good links with the local community and other health and social care organisations. The home had held a 'Nurses' day' in May 2017 and invited nurses involved with the home to a buffet lunch. Local nursery school children visited the home regularly and other visitors to the home included the local library and representatives from the local church. The manager told us some of the people who used the service had recently visited a local bowls club and they were hopeful of making that a regular occurrence.

At the previous inspection it was identified that the quality assurance process was, "work in progress". At this

inspection we looked at what the provider did to check the quality of the service, and to seek people's views about it. The manager had an audit matrix in place, which recorded when each audit was due and whether it had been completed. Monthly audits included care documentation, accidents and incidents, medication, bed rails, the dining experience, equipment, infection control, nutrition, kitchen, complaints, safeguarding, activities and falls.

We looked at a sample of care documentation audits and found they were predominantly compliant but where any issues had been identified, actions were put in place. For example, in one audit the moving and handling risk assessment and diet notification record were overdue a review. These had been actioned.

The regional manager conducted an audit of the home on a monthly basis and any actions were recorded on a 'Monthly remedial action plan'. This included a review of medicines, care documentation, management, health and safety, staffing, safeguarding, finance, environment, complaints, training and deprivation of liberty.

Residents' and relatives' meetings took place regularly. A meeting was taking place on the first day of our inspection visit. We looked at the minutes of previous meetings and saw the agenda included maintenance, activities, meal times and a visit by local nursery school children.

A survey of family members had been carried out in March 2017 and received 28 responses. Family members were asked to comment on the quality of the care, staffing, communication, leadership and what improvements could be made. The majority of responses were positive and rated the service either 'Excellent' or 'Good'. Where issues were raised, comments were analysed to identify the problem and these were fed back via the home's 'Questionnaire, suggestions and comments' notice board. This included feedback from the manager on any issues that had been raised. For example, people and family members had asked for more activities, more outings, better communication and menu choice. The manager's feedback stated that activities had been increased to seven days per week commencing July 2017, and a minibus had been purchased and outings had been arranged. The manager, staff and people we spoke with confirmed this. The manager also told us feedback on the survey was provided at the most recent residents' and relatives' meeting.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.