Heltcorp Limited

Goole Hall

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

Overall summary

This inspection took place on 27 November 2014 and was unannounced. We previously visited the service in November 2013 and found that the registered provider met the regulations that we assessed.

The service is registered to provide personal care and accommodation for 28 older people, some of whom have a dementia related condition. A day care unit has recently been created on the ground floor; this is used by people who live at the home as well as people who visit for the day. The home is on the outskirts of Goole, in the East Riding of Yorkshire and is located within its own grounds.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 29 January 2014. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe living at the home. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident all staff would recognise and report any incidents or allegations of abuse.

Staff told us that they were happy with the training provided for them and the training records evidenced that staff took part in a variety of training that would equip them to carry out their roles effectively. People who used the service, relatives and health care professionals told us that staff were effective and skilled.

The registered manager was aware of guidance in respect of providing a dementia friendly environment and progress had been made towards achieving this. Staff had undertaken training on dementia awareness and the Mental Capacity Act 2005 (MCA). This helped them to understand the care needs of people with a dementia related condition.

Staff had been recruited following the home's policies and procedures to ensure that only people considered suitable to work with vulnerable people had been employed. We saw that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. We found that medicines were safely managed.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People told us that staff were caring and this was supported by the relatives we spoke with.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided.

People who lived at the home, relatives and staff told us that the home was well managed. A senior member of staff had been promoted to the position of deputy manager and this meant that there was a manager on duty when the registered manager was not at the home.

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?

Good

Care provided was safe.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

We found that there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met. Staff were recruited following policies and procedures that ensured only those considered suitable to work with vulnerable people were employed.

The arrangements in place for the management of medicines were satisfactory; medication was stored safely and record keeping was accurate.

Is the service effective?

Good

Staff provided effective care.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood how to protect the rights of people's who had limited capacity to make decisions for themselves. We saw that progress had been made towards providing a dementia friendly environment.

Staff undertook training that equipped them with the skills they needed to carry out their role.

People's nutritional needs were assessed and met, and people told us that they were happy with the meals provided by the home. We saw that staff provided appropriate support for people who needed help to eat and drink. People had access to health care professionals when required.

Is the service caring?

Good

Staff at the home were caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

People were encouraged to be as independent as possible, with support from staff. We observed that people's individual care needs were understood by staff.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for their care were recorded and these were known by staff.

We saw that people were able to take part in their chosen activities and their visitors were made welcome at the home.

Summary of findings

There was a complaints procedure in place and people were informed about how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Good

The home was well led.

There was a registered manager in post at the time of the inspection. A deputy manager had been appointed and this meant that there was a manager available when the registered manager was not at the home.

There were sufficient opportunities for people who lived at the home and relatives to express their views about the quality of the service provided.

The manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked at the home.

Goole Hall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the registered 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 November 2014 and was unannounced. The inspection team consisted of an adult social care inspector 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. The expert-by-experience who was part of the inspection team on this occasion had experience of regulated services for older people.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the home and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

On the day of the inspection we spoke with five people who lived at the home, four relatives or friends, two members of staff, the deputy manager and the registered manager. We also spoke with three health care professionals who visited the home on the day of the inspection, and another following the inspection.

We spent time observing the interaction between people who lived at the home, relatives and staff. 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 could not talk with us.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people who lived at the home, staff records and records relating to the management of the home.

Good

Is the service safe?

Our findings

We spoke with five people who lived at the home and we asked them if they felt safe; they all told us that they did. One person said, “Yes, people around night and day” and another said, “Yes, because I have a lock on the door.” A visitor told us that they felt their relative was safe as, “There is always someone here."

Care plans included assessments that identified a person’s level of risk. These included a nutritional assessment, a moving and handling assessment and a pressure care assessment. Assessments and risk assessments included information for staff on how to reduce the identified risks and these had been reviewed regularly. For example, one care plan recorded, “If (the person) becomes argumentative, do not respond. Use distraction methods, change the subject or change the staff member to alter her mind set.” We saw that suitable mobility equipment was in place to enable staff to move people safely and on the day of the inspection we saw staff carrying out safe transfers.

We checked the staff rotas and saw that staffing levels were consistency maintained. Any staff absences had been covered whenever this was possible. The staff who we spoke with confirmed this. They said that the manager or deputy manager always tried to cover staff absences although sometimes when staff rang in at very short notice, this had not been possible. Staff told us that the registered manager would assist them at these times or if there was an emergency situation. We saw that the rota included the name of the senior staff member who was ‘on call’ overnight and at weekends.

Ancillary staff were employed in addition to care staff; this included cooks, domestic staff and maintenance staff. Although care staff had to help with the preparation of the tea-time meal, they were able to spend most of their time concentrating on supporting the people who lived at the home.

People who lived at the home told us that there were enough staff on duty. One person said, “There are enough staff – sometimes they are short staffed but they still manage.” However, another person told us that they sometimes had to wait for attention. Visitors who we spoke with told us that they had observed that there were usually sufficient numbers of staff on duty.

The registered manager told us in the PIR that fifteen staff had undertaken training on safeguarding vulnerable adults from abuse. There were safeguarding policies and procedures in place and the registered manager submitted alerts to the local authority as required. We spoke with the local authority safeguarding adult’s team and they told us they had received appropriate alerts from the registered manager.

Staff who we spoke with were able to describe different types of abuse. They were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt all staff within the team would recognise inappropriate practice and report it to a senior member of staff. A health care professional told us that there had been a recent safeguarding investigation at the home and they had seen some improvements in staff practices since then.

We checked the recruitment records for two new members of staff. Application forms had been completed that recorded the applicant’s employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to people commencing work at the home. Two written references had been obtained for one new member of staff but we noted that the references for the other person were verbal, although the registered manager had recorded the conversation he had with the referees. We reminded the registered manager that the systems in place to obtain employment references had to be robust so that the identity of the person supplying the reference could be confirmed. The records seen evidenced that only people considered to be suitable to work with vulnerable people had been employed.

We asked people who lived at the home if they received their medication at the right time and they all confirmed they received their medication when they needed it.

We saw that the medication trolley was stored in the ‘nurse station’ and was securely fixed to the wall. There was a dedicated medication fridge and we saw that fridge temperatures were recorded on a daily basis. In addition to this, the temperature of the room was also recorded each day. These daily checks ensured that medication was stored at the correct temperature.

Good

Is the service safe?

Medication was supplied in 'pods' that recorded the person's name and the name of the tablet. The 'pods' were colour coded to match the colours recorded on the medication administration record (MAR) chart to identify the times that the medication needed to be taken. There was a separate MAR chart for 'as required' (PRN) medication that included a protocol for the use of this type of medication. The pharmacy had also supplied body maps to identify the area of the body where creams should be applied. We checked MAR charts and saw that recording was satisfactory, although we reminded the deputy manager that it was good practice for two staff to sign hand written records to reduce the risks of errors occurring.

The system in place to check that the medicines prescribed by the GP were the same as those supplied by the pharmacy was not robust. This was discussed with the senior staff member responsible for the management of medicines who described a system they had used previously until they were advised that it was no longer needed. They assured us that the system would be re-instated immediately. There was a system in place to audit the management of medicines.

We checked the storage and recording of controlled drugs (CD's) and saw that this was satisfactory. We checked a random sample of CD's and the balance of medicines corresponded to the records in the CD register. We checked the records for medicines returned to the pharmacy, including CD's, and saw that these were satisfactory. Training records evidenced that the registered manager, three senior staff and three care staff had completed medication training. In addition to this, another two care staff were undertaking this training. This ensured that there was always a member of staff on duty who was able to administer medication.

We did not check the environment in any detail on the day of the inspection. However, we noted that the stairs to the basement (which were only used by staff) were not safe. They had been checked by the handyman, who had arranged for a more experienced person to carry out the necessary repairs. We also saw that the drive was full of pot holes. This was mentioned by a relative who was visiting the home on the day of the inspection. Following the inspection we contacted the registered provider to ask them to tell us when these repairs had been carried out. The registered provider contacted us on 22 December 2014 to tell us that the stairs had been repaired and the handyman had started to repair the driveway to the home.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. Discussion with the registered manager showed that they understood the principles of the MCA and when it would be appropriate to submit a Deprivation of Liberty Safeguard (DoLS) authorisation form to the local authority.

The registered manager told us that nine people who lived at the home had been diagnosed with a dementia related condition. The information supplied to us in the PIR recorded that eight staff had undertaken training on dementia awareness and 14 staff had undertaken training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This meant that staff were aware of the principles of capacity, decision making and restraint. People who lived at the home told us that they were consulted about their care. One person said, "Yes, I am in control." Two people who we spoke with told us that they were asked where they would like to sit to eat their meals and added, "(Staff) would always ask for consent." We observed that, when staff were assisting people to mobilise or transfer, they sought consent first.

No specific dementia care model was being followed at the home. However, the registered manager was aware of guidance from the Alzheimer's society and from the Care Quality Commission on dementia care and had started to make environmental changes. For example, there were clear signs to direct people to the lounge, dining room and bathroom and staff wore different coloured uniforms to identify their role. We saw a large clock and date board that clearly recorded the day and time. Bedroom doors were painted in different colours and had been made to look like a 'front door'. Different artwork was being considered to place on each person's bedroom door so that they could more easily identify it as their room. This indicated that progress had been made towards creating a dementia friendly environment.

There were plans in place to open a 'Dementia Café' within the day care unit and discussions had taken place with Admiral nurses (nurses who are specialists in the field of dementia care) to become involved. It was anticipated that this involvement would provide support and advice to people who used the day care service and people who lived at the home, and their relatives.

We saw that people's care plans recorded if a person had been diagnosed with Alzheimer's or another dementia related condition. Care plans also recorded a person's capacity to make decisions. One care plan that we reviewed recorded, "Staff to encourage (the person) to make all choices in respect of all daily needs and support tasks but must assess at the point of care whether or not the choice is appropriate to the task.

In one of the care plans we reviewed we saw that the person had a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) form in place. The form had been signed by the person's GP and recorded that the decision had been discussed with the person's relative and consultant.

We asked people who lived at the home if they were able to make decisions about their care and they all told us that they were happy with their involvement in decision making. Relatives told us they were involved in decision making when this was deemed to be appropriate. We discussed this with the registered manager and it was clear they were aware of the need to arrange best interest meetings when people did not have the capacity to make decisions for themselves.

We checked the individual training records for five members of staff and the overall training record. The overall training record identified which training should be completed by senior staff, which training should be completed by care workers and which training should be completed by kitchen staff. There was also a list of additional training that people could request to undertake. We saw that most staff (including ancillary staff) had completed training on documentation, behaviour that challenged the service, infection control, fire safety, food hygiene, moving and handling, safeguarding vulnerable adults from abuse and the Mental Capacity Act 2005 (MCA). Some staff had also completed training on end of life care, falls awareness, oxygen therapy, continence, health and safety, catheter care and dementia awareness. In addition to this, a number of staff had achieved National Vocational Qualification (NVQ) or equivalent at Level 2 or 3.

Good

Is the service effective?

The overall training record identified which training should be completed by senior staff, which training should be completed by care workers and which training should be completed by kitchen staff. There was also a list of additional training that people could request to undertake. We saw that most staff (including ancillary staff) had completed training on documentation, behaviour that challenged the service, infection control, fire safety, food hygiene, moving and handling, safeguarding adults from abuse and the Mental Capacity Act 2005 (MCA). Some staff had also completed training on end of life care, falls awareness, oxygen therapy, continence, health and safety, catheter care and dementia awareness. In addition to this, a number of staff had achieved National Vocational Qualification (NVQ) or equivalent at Level 2 or 3.

Staff who we spoke with were able to tell us about recent training they had attended and told us that they felt the training they received kept them up to date with good practice guidance. One member of staff said, however, that it would be preferable to spread the training over the year rather than it been condensed into just a few days. We discussed this with the registered manager who said that he was aware of this issue and had fed this back to the registered provider for consideration. Staff confirmed that they completed induction training when they were new in post and that this included shadowing experienced staff.

We asked people who lived at the home if they thought staff had the right skills and attitude to carry out their role. One person told us, "Yes, they are good at what they do" and another said, "Yes – they are good – all of them are good." We also discussed this with visitors and they all responded positively. One visitor said, "Yes, very, (their) hearts are all in the right place."

There was a record of any contact people had with health care professionals, for example, GP's and Speech and Language Therapists. This included the date, the reason for the visit / contact and the outcome. We saw advice received from health care professionals had been incorporated into care plans. Details of hospital appointments and the outcome of tests / examinations were retained with people's care records. A health care professional told us there had been a recent safeguarding investigation at the home and they had seen some improvements in staff practices since then. They said staff were now more likely to ask for advice appropriately.

We asked people who lived at the home if they were able to access their GP or other health care professionals when they needed them. They were all able to tell us about occasions when staff had contacted the doctor on their behalf. Two GP's who we spoke with told us they were called out to the home appropriately and they were not called out for 'trivia'. They said they had every confidence in the staff and they had no evidence to suggest that staff did not follow their advice. They added that they had received positive feedback from relatives about the care provided by staff, who were very 'personable'.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are unable to verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs. This meant that hospital staff would have access to information about the person's individual needs.

Assessments had been completed to identify any risks to a person due to poor nutrition. We saw that care plans recorded any special dietary needs and that, when nutrition had been highlighted as an area of concern, food and fluid charts were used to monitor a person's dietary intake. People were also weighed on a regular basis as part of nutritional screening. When concerns had been identified about people losing or gaining too much weight, advice had been sought from a dietician.

We saw that people's preferences were also recorded. One care plan recorded, "I like a beer with my lunch." We asked people who lived at the home about the meals provided and the responses were positive. People told us, "Excellent – top class hotels can't beat these meals" and "Dinners are generally good." People told us that drinks were available throughout the day and night.

The mealtime was promoted as a pleasant experience. We observed staff assisting people to eat and drink and noted that this was unhurried and carried out with a caring approach. When people had difficulty making a choice about which meal they preferred, staff assisted by showing them both meals on offer.

Good

Is the service caring?

Our findings

We observed that staff displayed kindness and empathy towards people who lived at the home. People looked appropriately dressed, their hair was tidy, men were clean shaven (if that is what they had chosen) and they looked cared for. The staff who we spoke with were clear that they would treat people as individuals and promote their independence. They acknowledged that sometimes it took a long time for people to see to their own personal care and to mobilise, but understood that it was important for people to retain the abilities they had. They said that they were confident all staff were patient and allowed time for people to help themselves. We observed that staff were skilled in encouraging people to talk with them and to each other.

We asked people if they felt staff really cared about them and the responses included, "They do, definitely", They are good lasses" and "I think so, most nights someone looks in on me." However, one person did say, "I think they are caring – sometimes a bit rushed around lunchtimes." The relatives and the health care professionals who we spoke with told us staff were kind, considerate and caring, although one health care professional told us some staff were more skilled and caring than others.

People told us that staff encouraged them to be as independent as possible and people said staff allowed them the time to do things for themselves. One person said, "Of course, yes. They don't hurry me", another said, "Yes, can make own drinks" and another said, "They always ask if there is anything else they can do for you." This indicated that people were consulted about their need for assistance. Relatives also spoke positively about this. One relative said, "They got (my relative) walking when others said she wouldn't walk again."

We saw that one person's toe nails were very long. We mentioned this to the registered manager who told us that this person had refused to see a chiropodist on several occasions and they were aware that they needed to consider taking further action to ensure that the person received the care they needed, such as a best interest meeting.

We observed that people's privacy and dignity was promoted by staff. We saw that staff knocked on bedroom doors before they entered. On the day of the inspection a health care professional visited to check someone's dressings. The person refused to move from the lounge and staff brought a screen to place around the area so that the health care professional could carry out the treatment without other people being able to observe. People who lived at the home told us that their privacy and dignity was respected. One person said, "They are there when I want them and not there when I don't." We also heard a staff member suggest to some visitors that they used the 'quiet' room so that they could have a private meeting with their relative.

One of the members of staff who we spoke with told us they were undertaking training so that they could become the dignity champion for the home. They told us that they were also considering appointing an end of life care champion. This indicated that staff realised the importance of keeping up to date with good practice guidance.

Staff told us that they had a handover meeting at the changeover from one shift to the next. They told us that this ensured information was shared between all members of the staff team. They said that communication between staff, and between the care staff and managers, was good and this ensured they were aware of people's up to date care needs. Staff told us they looked back over several days in the handover notes if they had been off work so they were brought up to date with people's current care needs.

The health care professionals we spoke with told us that, when they visited the home and spoke with staff, the staff were always aware of the person's specific health care needs. People who lived at the home told us that staff were aware of their needs. One person said, "They do because they get to know you."

None of the people at the home had required the advice of an advocate but information was available so that it could be given to people if they made enquiries.. There was an information folder in the reception area and this included leaflets about funding care, the Alzheimer's society, the safeguarding vulnerable adult's team and SAGA (a company that provides services such as insurance and private healthcare for people over the age of 50).

Good

Is the service responsive?

Our findings

We saw in care plans that people's needs had been assessed when they were first admitted to the home, that care plans had been developed to record people's individual needs and that care plans were regularly reviewed and updated accordingly. We noted that care plans included information about a person's previous lifestyle, their hobbies and interests and their family relationships. We overheard conversations between people who lived at the home, relatives and staff and it was clear that staff knew people well, including their likes and dislikes and their individual preferences for care. Relatives told us they were always made welcome at the home and we saw that they were made welcome on arrival.

Assessment tools had been used to identify the person's level of risk. These included those for pressure care, tissue viability and nutrition. Where risks had been identified, risk assessments had been completed that recorded how the risk could be managed or alleviated.

Care plans included details of a person's medical conditions and any special care needs they had to maintain their general health. Information about some health care conditions was included in care plans to ensure staff were aware of the person's specific needs. People's assessments and care plans were reviewed on a regular basis to ensure that there was an up to date record of the current health care needs.

We observed that staff were able to recognise changes in a person's behaviour that indicated they were not well, when they were unable to express this verbally. One person's care plan recorded, "Sideways / slow paced walking – this indicates I am tired. Bending over and / or holding stomach and / or head means I am in pain." Care plans also included advice for staff on how to manage a person's behaviour. For example, one care plan recorded, "If I put something in my hands as simple as a ball of wool this may stop me collecting other people's belongings."

There was an activities board on display and we saw the activity listed for the day of the inspection did take place. We asked people who lived at the home if activities were available and if they suited their needs. We were told that they took part in bingo, quizzes, chair exercises, sing alongs and playing with an activity ball. On the day of the inspection three females told us about a planned Christmas shopping trip that they were looking forward to. We also observed that staff spent time chatting to people throughout the day.

Staff who we spoke with told us that they had time to sit and chat with people in the afternoons and that more formal activities took place on Mondays, Wednesdays and Fridays.

We saw the registered manager take a 'rummage box' to a person who had dementia. They initially showed little interest but the registered manager spent some time chatting to the person and they then started to pull things out of the box; this led to conversation and laughter and helped the person to reminisce about their previous lifestyle. A care worker brought some napkins into the lounge and asked one person who lived at the home if they would like to fold them ready for lunch; it was clear from conversation that this was a regular occurrence and that the person liked to be involved and 'busy'.

We carried out a Short Observational Framework for Inspection (SOFI) in the main lounge; this is a way of observing care to help us understand the experience of people who could not talk with us. The SOFI observation did not highlight any concerns about staff interaction with people who had a dementia related condition. We saw that staff communicated with people who had limited verbal communication by using appropriate touch, eye contact and gestures to help them understand and interact.

The complaints procedure was displayed in the home and there was an information leaflet in the reception area that included information about the home, information about how to complain and a complaints form ready to complete. The information displayed also invited people to make comments or compliments. We asked people if they knew how to express concerns or make a complaint. All of the people we spoke with told us that they would not hesitate to speak to staff, although one person said, "I don't think we've ever had any problems." A visitor told us that they would go to the office and they were sure that any problems would be sorted out.

We checked the complaints log and saw that there were two recent complaints recorded. One investigation had been carried out following a safeguarding referral that was made by CQC and another as a result of a complaint from a relative. The relative was informed of the outcome and

Good

Is the service responsive?

records evidenced that the relative was satisfied with the outcome. We noted that "What I have learnt / what I will do differently" forms were included with complaints records to record any learning as a result of investigations carried out.

We saw the supervision calendar; this evidenced that staff had supervision meetings two or three times a year. We also checked some individual staff records and saw records of supervision meetings. These are meetings that take place between a member of staff and a more senior member of staff to give them the opportunity to talk about their training needs, any concerns they have about the people they are supporting and how they are carrying out their role. Staff told us that they were well supported by the registered manager and deputy manager.

Good

Is the service well-led?

Our findings

We found the atmosphere at the home to be friendly and welcoming, and this was supported by the people who lived at the home, health care professionals and visitors who we spoke with.

The registered manager told us in the PIR document that a senior member of staff had been promoted to deputy manager. This meant that there would be a manager on duty when the registered manager was not present at the home. People who lived at the home told us that it was well managed and there was a positive atmosphere. They said they could get involved if they wished. One person said, "Yes, I think it is good" and another told us "Great atmosphere – everybody involved." Visitors told us that there was a positive culture at the home. One relative said, "(The staff) all know one another and work together."

People who lived at the home and relatives told us that they had not been asked to complete satisfaction surveys. However, we saw that surveys had been sent to relatives and to people who lived at the home during 2014. One comment in the relative survey was, "All the staff are always very friendly and obviously very patient and caring. An outstanding home we would never hesitate to recommend." The survey for people who lived at the home included questions about meals, social activities and responses to comments and complaints. We saw that feedback was positive.

People who lived at the home who we spoke with said 'resident's meetings' were not held at the home. However, we saw the minutes of meetings that had been held in June and October 2014. The minutes evidenced that eight people had attended the meeting in October and that meals, activities, laundry, housekeeping, management and staff had been discussed. This evidenced that there had been opportunities, both by completing surveys and attending meetings, for people who lived at the home to share their views about the service they received.

A staff survey had been carried out during 2014. Staff gave very positive feedback about the manager including, "Easy to get on with – if I need to ask a question or need to speak about something that's concerning me, I know I can speak to him." Staff were also positive about team work; comments included "Good team work between staff" and "I like coming to work." However, staff were not so positive about the organisation. They commented that they should receive praise more often, that there was a lack of opportunity for progression and that repairs needed to be completed. It was not clear what the organisation had done in response to these comments, although we were told that a deputy manager had been appointed and that a full-time handyman was employed.

Staff meetings were held; we saw that there were separate meetings for senior staff, night staff and kitchen staff, as well as full staff meetings. The most recent full staff meeting was in July 2014. Topics discussed included infection control, daily notes, housekeeping and menus. The minutes recorded that recording in care plans had 'much improved'. The staff who we spoke with confirmed that they attended staff meetings and these were a 'two way' process; information was shared with them but they got the opportunity to ask questions, raise concerns and make suggestions for improvement.

We saw that accidents and incidents were recorded and monitored. These had been analysed for the period January – December 2013 and then again for the period January – October 2014 so that comparisons could be made. The audits evidenced that, in most months, accidents had reduced. The audit folder included body maps, a 24 hour accident and falls observation record, a monthly accident audit form, a falls monitoring form and a document called "Managing falls and fractures in care homes for older people." These records indicated that accidents were being monitored and any identified areas for improvement were being carried out.

The registered manager had also carried out audits in respect of kitchen safety, care plans and pressure area care. These included a record of improvements that needed to be made and a record of when action had been taken. For example, the kitchen audit recorded, "Tiles in kitchen need grouting. This has been added to the maintenance plan for completion before 02/01/2015".

We checked the health and safety folder; this included an audit that had been carried out by the registered manager in October 2014 plus an environmental risk assessment and records of in-house safety checks. These included checks for emergency lighting, the fire alarm system and water temperatures, although we saw that water temperature tests had not been carried out in September and October. The registered manager told us that he would ensure these were taking place consistently.

Good

Is the service well-led?

We saw evidence that hoists and lifts were serviced regularly to ensure they were safe to use and that a portable appliance test had taken place in April 2014. The electrical installation had been tested in October 2011 and the certificate was valid for five years.

There were policies and procedures in place about how to deal with emergency situations such as flood and loss of power. However, these needed to be combined to form a contingency plan for the home. The registered manager and deputy manager told us that this work was already underway.