Manucourt Limited

Woodley Grange

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 11 and 13 October 2016 and was unannounced.

Woodley Grange is situated on the outskirts of Romsey. It is made up of an older building which has been refurbished and extended to provide residential care for up to 45 people. At the time of our inspection there were 41 people living at the home. The service specialises in caring for people with memory loss or living with dementia and provides respite care and day care. It does not provide nursing care. The service in arranged into three areas known as the Abbey, Broadlands and Mountbatten units. Each unit has their own communal sitting and dining area. Each room is for single occupancy with most having their own ensuite facilities. The rooms viewed were nicely personalised with people's own possessions and were well equipped with profiling beds. The service has a hair salon and a large activities room which was being redecorated at the time of our inspection. The secure garden has been professionally designed to provide a safe, secure environment for people living with dementia.

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

Care plans and other records relating to people's needs did not always contain sufficient information. This is important to support staff to deliver responsive care.

Staff understood the signs of abuse and neglect and demonstrated a commitment to ensuring people were protected from harm. Overall, staff had a good understanding of people's risks and how to support them to maintain good health and stay safe

There were sufficient numbers of staff deployed to meet people's needs. Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised.

Appropriate systems were in place for obtaining, storing and disposal of people's medicines and improvements were underway to ensure that people received their medicines and topical creams as prescribed.

People received a choice of meals and were supported appropriately to eat and drink.

Staff were supported to carry out their roles and received an induction and on-going training and supervision.

Staff sought people's consent before providing assistance. Where a person's ability to consent to living within the home, or to the use of safety monitoring equipment was in doubt, a formal assessment of their

capacity was usually undertaken as part of the care planning process. Relevant applications for a DoLS had either been authorised or were awaiting assessment by the local authority.

Staff had developed effective working relationships with a number of healthcare professionals to ensure that people received co-ordinated care, treatment and support.

People were cared for by kind and caring staff who respected their choices and were mindful of their privacy and dignity.

People told us they were able to express their views and to give feedback about the service. They were confident they could raise concerns or complaints and these would be dealt with.

People, their relatives and staff spoke positively about their leadership of the home. Systems were in place to monitor the quality and safety of the service.

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.

Appropriate systems were in place for obtaining, storing and disposal of people's medicines and improvements were underway to ensure that people received their medicines and topical creams as prescribed.

Staff had a good understanding of risks to people's health and wellbeing and measures were in place to protect people from risks associated with the environment. People were protected against the risk of abuse.

Sufficient staff were deployed to ensure people's needs were met in a timely manner.

Is the service effective?

Good

The service was effective

Staff were supported to carry out their roles and received an induction, on-going training and supervision.

People received a choice of meals and were supported appropriately to eat and drink.

People were supported to access healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were cared for by kind and caring staff who were mindful of their privacy and dignity.

Relatives told us they were kept well informed and that communication with the home was good.

Is the service responsive?

Requires Improvement

The service was responsive.

People's records did not always contain sufficient information about their needs and how these should be met.

People took part in activities of their choice which they enjoyed.

People told us they were able to express their views and to give feedback about the service. They were confident they could raise concerns or complaints and these would be dealt with.

Is the service well-led?

Good

The service was well led.

People, their relatives and staff spoke positively about their leadership of the home.

Systems were in place to monitor the quality and safety of the service.

Woodley 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.

This was an unannounced inspection which took place over two days on 11 and 13 October 2016. On the first day of our visit, the inspection team consisted of one inspector. On the second day the inspector was joined by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the service tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 12 people living at the home and three relatives. We also spent time observing aspects of the care and support being delivered. We spoke with the registered manager, a head of care, four care staff, the chef, two members of the activities staff and two housekeeping staff. We reviewed the care records of four people. We also viewed other records relating to the management of the service such as audits, incidents, policies, meeting minutes, training and supervision records and staff rotas.

Following the inspection we sought feedback from six health and social care professionals to obtain their views about the care provided at Woodley Grange.

The last inspection of this was service was in August 2013 when no concerns in the areas inspected.

Good

Is the service safe?

Our findings

People told us they felt safe living at Woodley Grange. One person said, "There is always someone around….you have not got to worry". Another person told us their medicines were managed well, they said, "Staff bring my pills when I need them". A relative told us, "We feel relaxed; they are being looked after and are safe". In a recent survey a relative had commented, 'I feel very secure in the knowledge that [the person] is safe in the home and well looked after'.

Medicines were stored in locked trolleys kept in locked medicines rooms. The temperature of all areas used for storing medicines was checked on a daily basis and provided assurance that medicines were stored within their recommended temperature ranges. Controlled drugs were stored securely. We checked 12 people's medicines administration records (MARs). These included the person's photograph, date of birth and information about any allergies they might have. Another person's MAR had not been signed to show that two medicines had been administered. Action was taken to address this with the staff member concerned. Changes were underway to ensure that there was an effective way to record the administration of prescribed topical creams and that staff had clear guidance about where and how often prescribed topical creams should be applied. We completed a random audit of the controlled drugs in stock. The CD's recorded in the CD register did not match those stored in the CD safe. Controlled drugs are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971 as there can be a risk of the medicines being misused. We made additional checks which showed that the medicines had either been disposed of or transferred out of the home but the CD register had not been updated. Arrangements were to be put in place to ensure that the CD register was reviewed as part of the medicines audit. This would help to prevent similar administrative errors occurring in the future

Staff were administering covert or 'hidden' medicines to several people. Where this was the case, staff had undertaken a mental capacity assessment to ensure that the person lacked capacity to make decisions regarding their medicines. Staff had consulted with relevant others to demonstrate that the use of covert medicines was in the person's best interests. Staff who administered medication had completed training and the registered manager or head of care had carried out competency assessments to ensure staff remained safe to administer people's medicines.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect and about what they must do if they suspected abuse was taking place. One staff member said, "Safeguarding is protecting people from abuse and harm…they are all safe here". Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. One care worker told us they would report any concerns, "Straight away, like if a resident had a sore, I would go straight to the care team manager, you don't leave it".

Information including the contact details of the local safeguarding team was available within the home and we were able to see that the registered manager had worked effectively with the local authority to investigate safeguarding concerns. A social care professional told us the registered manager had "dealt with the concern really well" and that the registered manager had been "Very open". They told us they had no

current concerns about the safety of people using the service". Staff were aware of the whistle-blowing procedures and were clear they could raise any concerns with the registered manager. They were also aware of other organisations with which they could share concerns about poor practice or abuse.

People told us there were sufficient staff deployed to meet their needs. One person said, "There are enough staff for my needs". A relative said, "There are always plenty of staff". Early shifts were staffed by a head of care, two care team managers and eight care workers. After 2pm there was a head of care, two care team managers and six care workers on duty. Night shifts were staffed by one care team leader and three care workers. We reviewed the rotas for a four week period; these confirmed the home was generally staffed to these target levels. The provider also employed a team of housekeeping staff, chefs and kitchen staff and two activities co-ordinators. There was also a maintenance person.

All of the staff we spoke with told us there was sufficient staff to meet people's needs safely. One staff member said, "There is enough staff most of the time, we are good at working together". Another staff member told us the registered manager and provider were good at listening to any issues they might have about staffing. They said, ""It used to be six carers in the morning, but we asked for more, we are happy now". The provider used a systematic approach to determining staffing levels. They had developed a tool to help them assess the dependency levels of people using the service. The tool considered a range of factors including the layout of the home. The tool was reviewed monthly and helped to ensure that staffing levels remained appropriate to people's needs. Our observations indicated that people's needs were being met in a timely manner and in line with their choices.

Systems were in place to assess and manage risks to people. People had moving and handling risk assessments and falls risk assessment. Equipment was used effectively to manage people's risks. For example, motion detector alarms were used to alert staff when people at high risk of falls were moving so that they could check on their safety. The registered manager told us that following a fall, incident forms and body maps were completed and each month a falls audit was completed. This reviewed the numbers of falls within the home, their location and time they took place. This helped to identify whether there were any themes of patterns to the falls and allowed remedial actions to be taken. Nationally recognised tools were used to monitor people's risk of malnutrition or of developing skin damage. Overall, staff had a good understanding of people's risks and how to support them to maintain good health and stay safe. We did however; observe two staff using inappropriate moving and handling techniques. One was an agency member of staff who was immediately supported by the head of care to assist the person in the correct manner. We brought this to the attention of the registered manager who arranged for both staff to undergo further training in this area.

The safety of the premises and of equipment used was monitored. A range of monthly fire checks were undertaken and checks were made to ensure that the lift, gas and electrical items were safe to use. Checks were also made of wheelchairs, call bells and window restrictors to ensure these were in good working order. Risk assessments had been undertaken of the fire risks within the service and of the water system to ensure the effective control of legionella. The provider had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service.

Appropriate recruitment checks took place before staff started working at the home. The provider had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. Staff were asked to confirm that there had not been any changes to their criminal record on an annual basis. We did note that in the case of one staff

member, the registered manager had not ensured that a full employment history was obtained. This has since been obtained.

Good

Is the service effective?

Our findings

People and their relatives told us the service provided effective care. A relative told us, "We are very lucky… we have not regretted the decision, [their relative] is very settled". Another relative said, "[the person] has got on splendidly" since moving to the service, "We are extremely pleased". Health and social care professionals also felt staff provided effective care. One said, "The staff are really helpful, they give me the time, introduce me to the patient, my advice is followed through, they are swift in making referrals… the head of care has been exceptional, they have always helped, even if it has put them behind with what they were doing".

People were positive about the food provided. One person said, "It's quite good actually". Another said, "The food is nice, you get a choice". Hot and cold drinks and fresh fruit were readily available throughout the day. At lunch, meals were either served in the dining room, or delivered to people in their rooms. Adapted cutlery such as plate guards and lidded cups were available to assist people with remaining independent with eating and drinking. Plates were brightly coloured allowing people to distinguish food items, supporting them to enjoy their meal whilst encouraging the amount of food eaten. Kitchen staff had information about people's specialist diets including those that required diabetic meals and those that needed soft or pureed food. We were told that a food profile was completed for each resident which included information about their likes and dislikes and where they liked to eat.

People's weight was monitored on a monthly basis and there was evidence that people who were losing weight were encouraged to take have regular snacks or smoothies. We noticed that one person had lost 4.9 kg in the last month but had not been referred to the GP. The registered manager told us that staff were encouraging extra snacks and fortified foods and that they were due to be weighed again. If this showed continued weight loss, they would be referred to the GP at that point.

Staff received appropriate support to perform their role effectively. New staff completed an induction during which they learnt about their role and responsibilities and undertook some essential training. Staff who were new to care were being supported to complete the Care Certificate. The Care Certificate was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. Agency staff also underwent an induction to the service which included a tour of the home and reading the fire procedures.

Staff had completed training in a range of subjects such as infection control, Mental Capacity Act (MCA) 2005, fire safety, safeguarding, equality and diversity and manual handling training. Staff had also completed additional training relevant to the needs of people using the service. For example, staff had recently had training on slips, trips and falls. All staff completed a one day course on caring for people living with dementia; the care team leaders completed a two day course. The registered manager was also a dementia champion which had enabled them to give talks about the condition and support relatives of those living with dementia. Training was completed in caring for the dying and senior staff undertook training in person centred care planning. Plans were in place to introduce training on caring for pressure ulcers. Overall staff told us the training provided was adequate to enable them to perform their role effectively and records showed that this training was mostly up to date.

Staff told us they felt well supported in their role and were able to seek guidance from the head of care or the registered manager when this was needed. Staff received formal supervision periodically and some had received an annual appraisal. Records showed that currently supervision was mainly observational with staff being assessed in practical skills such as making beds or tidying rooms. Improvements were planned which would ensure that supervision was an opportunity for staff to discuss matters relating to the needs of people using the service and develop their own skills and knowledge.

Staff sought people's consent before providing assistance, for example, we observed staff asking people, "Would you like to come to the dining room" and "Have you had enough lunch". The registered manager showed us a new consent form that was being introduced. This recorded people's consent to specific aspects of their care and support such as personal care or for staff administering their medication. Where a person's ability to consent to living within the home or, to the use of safety monitoring equipment, was in doubt, a formal assessment of their capacity had been undertaken as part of the care planning process. Staff had been involved alongside other professionals and family members in reaching best interests decisions about how certain aspects of peoples care and support should be provided such as the use of covert medicines. The MCA 2005 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. However, some people living at the home were also unable to consent to other aspects of their care and support, such as being assisted with personal care or with eating and drinking, but there was no mental capacity assessment in place regarding these decisions. A number of care plans contained statements such as the person 'lacks capacity' but it did not record what decision or action this related to. Recording decision specific mental capacity assessments and undertaking best interests consultations with relevant people and professionals is important to ensure that staff can demonstrate they are following the principles of the MCA 2005 at all times. Staff had received training in the MCA 2005 and understood their responsibilities with regards to this. One staff member said, "If people lack mental capacity we need to give proper care for their wellbeing…we need to make decisions on their behalf".

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had either been authorised or were awaiting assessment by the local authority. A list of which people who were subject to a DoLS was displayed in the staff room to help ensure staff were aware of the safeguards that were in place.

Registered managers and providers are required to send statutory notifications to the Care Quality Commission (CQC) when a significant event occurs. One type of significant event is when the local authority approve an application to restrict a person's liberty to protect them from harm. Applications for a DoLS had been approved by the local authority for two people living at the service but a notification had not been submitted. The registered manager was fully aware that the notifications should have been sent and has since rectified this oversight.

Where necessary a range of healthcare professionals including GP's and community nurses had been involved in planning people's care and support. We were able to see that staff referred people for review by the GP if they were concerned about their dietary intake, following falls or due to showing signs of having chest or urine infections. People had been referred to the falls team or to occupational therapists when there were concerns about their mobility. Staff worked with the community mental health team to support

the needs of people living with dementia or behaviour that might challenge others. We were told that staff had completed behavioural charts for two weeks so that the person's behaviour patterns might be monitored and their needs assessed and treated. This helped to ensure that people received co-ordinated care, treatment and support. A visitor told us that they were very happy with their relatives' health care. They said, "They [the staff] know what's going on, if they have been unwell, they know their needs". The service maintained hospital transfer forms. These contained key information that could be shared with hospital staff in case of admission to hospital. We did note that these focused on the person's physical care needs rather than their emotional and psychological needs, and how this affected their mental health and wellbeing. Including this information would help to ensure that hospital staff were able to deliver person centred care.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and caring staff. One person said the care workers were all "Very good, very kind". A relative told us, "[the person] is content; the staff are cheerful and welcoming". Another said, "The Staff are very helpful and caring". A health care professional told us, "I have seen lots of interactions [between people and staff] and I have never had any concerns". Another said, "They are very good with caring".

Our observations indicated that overall staff interacted with people in a kind, patient and caring manner. The atmosphere in the communal areas was quiet and peaceful and people looked relaxed and settled in the company of the staff. Some staff were more skilled that others at engaging with people. For example, we saw there were some missed opportunities for a small number of staff to engage with people whilst completing care tasks or during quiet times of the day. Most, staff however interacted in a positive and encouraging manner with people. For example, we saw staff supporting one person to eat their lunch. They said, 'Oh that looks nice' and 'Just one more mouthful'. We observed that they gently encouraged the person to use the cutlery to eat their meal as independently as possible. When they had finished they said, "That's brilliant".

The registered manager demonstrated a commitment to ensuring that the staff team were kind and caring. They explained that recruiting and retaining a caring staff team was key to this. This they said started at the interview which was used to assess whether prospective staff were empathic and had a passion for the role. They said, "We can teach people how to care, but they have to have the caring side". Part of the induction of new staff focused on ensuring they understood the organisations values and felt confident putting these into practice. The staff talked fondly about the people they supported and were confident that their colleagues were also kind and caring. One staff member said, "The residents are just like my parents". Another care worker said, "Oh yes they [the staff] are all kind and caring, really amenable, very friendly, this place is the best".

People told us they were treated with dignity and respect. Staff told us how they knocked on people's doors before entering, or placed a towel across the person's lap when assisting them with personal care. Our observations during the inspection indicated that people were dressed appropriately and that attention had been paid to their appearance, for example, their hair brushed and facial hair shaved. A social care professional told us that when they visited "The staff have been positive and polite to residents, engaging in conversation. Residents have been well presented".

Relatives told us they were kept well informed and that communication with the home was good. They were free to visit the home at any time. Relatives told us they, and their extended family, felt very welcome and it was clear they had also had a good relationship with the staff team and the registered manager.

People were supported to follow their religious and spiritual beliefs and a local church visited to offer pastoral support. Basic end of life or advanced care plans were in place, but the registered manager told us that these were developed and added to as people reached the end of their life. This helped to ensure that

there was a record of the person's wishes in relation to how they would like their care to be managed in their final days and following their death. We saw that were a number of letters and cards from families thanking staff for providing compassionate care in their relative's final days.

Requires Improvement

Is the service responsive?

Our findings

People told us their complaints or concerns were taken seriously and that their views were listened to. This was echoed by their relatives. One relative said, "We have seen the care plan, they do a quarterly review, [the person] is present, she can have her say if there are any problems". People were also supported to take part in social activities in line with their wishes which they told us were enjoyable.

People's needs were assessed before people came to live at the service. This helped to ensure that the staff would be able to meet their needs safely. Following their admission, each person was involved in drawing up a comprehensive care plan which described their needs and how these were to be met. These care plans were now accessed via an electronic system. Staff used hand held tablets or computers to write, update and read people's care plans which covered areas such as how the person communicated, their personal care needs, the support they needed with medicines or with their mobility. Whilst the care plans viewed generally reflected people's current needs, there were areas where they could be more detailed. For example, one person was living with a specific condition but their care plan did not include information about the nature of this disease and the impact it has on people's physical and emotional care needs. Their moving and handling assessment did not reflect the complexity of their needs. We had observed that staff lacked confidence in providing support to this person with their mobility and transfers. One of the care plans viewed did not contain sufficient information about the strategies and interventions staff should follow when responding to incidents of aggression or behaviour which might challenge others. This is important as it ensures staff provide a consistent approach to managing people's care.

One person who was at risk of poor nutrition had no information recorded in their nutrition plan. One person's nutrition plan did not record the specialist equipment they used for eating and drinking. Some of the care plans viewed contained incorrect or inaccurate information about people's needs. For example, one person's nutrition plan stated they had been prescribed thickened drinks. This was not the case. Another person's communication plan contained contradictory information. It stated the person was able to communicate if they were in pain, but could not always communicate discomfort. Their skin integrity plan stated the person could move in bed independently, but the next sentence said they needed assistance to turn at night. This person had developed a pressure ulcer on their foot, but the care plan did not describe in detail the measures that were being taken to manage this, such as how often they were to be turned at night.

Some of the protocols in place for PRN or 'as required medicines could be more detailed. For example, one person was prescribed as required medicine to manage agitation or aggression. The protocol said staff should try and prevent the person from becoming agitated or distressed by 'using distraction techniques' or 'engage them in an activity'. There was no detail about what activities the person enjoyed and might therefore be most effectively used by staff to de-escalate behaviour. People did not have PRN protocols in place for the use of medicines prescribed for pain relief. Detailed and personalised PRN protocols help to ensure that all staff, including agency staff, were able to provide a consistent response to people's individual signs of pain particularly where people were no longer able to communicate this. We spoke with the registered manager about this who took immediate action to put these in place. We noted that where staff

had administered PRN medicines, they had not recorded the rationale for the use of the medicine on the reverse of the MAR. This is important to help identify trends or patterns in how the medicine is being used. One person was living with diabetes and staff were regularly testing their blood sugar levels. However the person did not have a clear escalation plan which described the actions that staff should take if the person's blood sugar levels were outside of certain parameters. Escalation plans are important as they help staff to provide appropriate interventions and also assist them to recognise and respond to changes in people's health. Elements of the handover form we were given were also out of date and did not reflect people's current needs.

As the electronic care planning system was in the early days of being implemented it was not possible for us to determine how effective it was going to be. Staff had only been using the electronic care planning system for a short time and the registered manager was confident that as staff became more familiar with the system improvements would be made to the quality and accuracy of some of the information recorded. Staff told us the electronic records were effective and were "easier to use and took less time" than completing paper records. A staff member told us this enabled them to spend more time with people using the service. We found the system contained a number of features that helped to effectively monitor and review risks to people's health and wellbeing. For example, key information about people's risks such as whether they were on 'nutrition watch' or were subject to a deprivation of liberty safeguards authorisation, were clearly displayed on the hand held tablets used by staff. Staff were able to use the tablets anywhere in the home, allowing them to make contemporaneous updates to people's care plans. Each person's electronic dashboard noted the care tasks that had taken place and those that were due, such as helping people to reposition or to eat and drink. We reviewed the food and fluid charts for two people. These provided a clear record of how much of their meal the person had eaten and demonstrated that they had been offered regular fluids throughout the day. The registered manager was able to monitor each person's record more effectively and would be alerted for example, if people's care plans had not been reviewed each month. The system also created graphs from the data entered which enabled the registered manager to analyse the information, helping to identify trends of themes that might for example, be contributing to falls.

A range of activities were provided. Two staff were employed to lead the activities provision within the service. They provided a range of both group and one to one activities for people and spoke with us in an enthusiastic manner about their role. They were very knowledgeable about people's likes and dislikes and were aware of those that preferred quiet time or one to one interaction with staff. Staff completed an 'Activities I enjoy' when a person first came to live at the service. Picture cards were used to help people identify preferred choices if they were no longer able to express this verbally. A schedule of activities was advertised and included games, bingo and sing a longs. The staff facilitated a knitting club during which people were being supported to knit blankets for a local baby unit which some people had visited to deliver the blankets. People could attend exercise or flower arranging classes. The home did not have a mini bus, but the previous year, they had hired a mini bus and taken a small number of people on a trip to the seaside. This was still remembered by one person who told us, "I very much enjoyed the trip laid on by the Home for Residents to go to Bournemouth for the day". The staff described how when people were living with more advanced dementia, they provided sensory experiences such as music or singing, but described how one person had responded positively to be read poetry. Taste was also used to stimulate people's senses. 'Fruity Friday' involved trips to the supermarket to buy sweet and sour fruits for people to try. We observed staff playing Quoits with people and bingo. Some people were having their nails painted. These activities were well received people who were all encouraged to join in.

People told us they were able to express their views and to give feedback about the service. An annual survey had been undertaken with people and their relatives, the results had been shared and a

management response provided. The feedback in the survey was positive with comments such as 'Manager helpful' and 'Good range of activities'. A relative had commented, 'Mum has been treated very well'. Meetings with people took place regularly and were used as an opportunity for people to make suggestions and to comment on the service provided. For example, at a residents meeting in August 2016, issues such as the environment, the food and staff and management issues had been discussed. People had also started to get involved in the recruitment of new staff. For example, one person had recently been involved in the recruitment of a chef.

Complaints policies and procedures were in place. Information about how to make a complaint was displayed within the home and available in the agreement or service user guide given to people when they first came to the service. There had not been any complaints within the last 18 months, but prior to that we were able to see that records were kept of the actions taken in response to complaints received. People told us they were confident they could raise concerns or complaints and these would be dealt with. One person said, "I would go to [the registered manager], I would go straight to the top". The service had received a large number of compliments. Trends in the feedback provided included, the kindness and helpfulness of staff. One compliment read, '[the person] was very unsettled for the first week, but thanks to the kindness and encouragement of the staff, they were soon going into the lounge and joining in. Nothing is too much trouble for them and we are always made to feel welcome'.

Good

Is the service well-led?

Our findings

People and their relatives spoke positively about the registered manager and their leadership of the home. Comments included, "[The registered manager] is brilliant, very good, very approachable". A staff member told us, "Yes you always see [the registered manager] around, they are very good at appearing round corners!" Another said, "We have a lovely manager, they are very kind to us, they spend time on the floor". This was echoed by a third staff member who said the registered manager, "Goes round every morning to check everyone". A health care professional told us the service was well led, they said, "Its professional, very well structured, everything I ask for is followed through, I recommend the home to others in the community".

Staff were clear about their role and responsibilities. They told us that allocation meetings were held daily with staff being assigned to specific units and tasks, although this was changed on a regular basis which they felt helped to ensure that they knew all of the residents and their needs. Staff meetings also took place periodically. These meetings were used to share developments with staff and to discuss how the delivery of care could be enhanced. Staff surveys took place and sought feedback from staff about issues such as whether they felt they were given supportive feedback about their performance or felt able to talk to the management team. All of the responses were positive.

The registered manager and provider valued the staff team. Opportunities were also available for staff to gain further qualifications and extend their skills and knowledge. The registered manager said, "If staff have had a bad day, I get them some chocolates just to say thank you, they need to feel appreciated…if you treat staff poorly, they will provide poor care". The provider also arranged Christmas parties for the staff; free flu jabs and provided daily snacks for them. A number of staff told us that they felt valued by the registered manager and provider. One care worker said, "They listen to us and try to sort out our concerns, they appreciate what we are doing". Staff told us that the service was a good place to work and that they enjoyed their job. One staff member said, "Morale is good, that's why I have stayed for so long". Another said, "I love it here, there is a good atmosphere, the staff are friendly, the manager or the head of care will do an action straight away". This all helped to ensure that people were cared for and supported by motivated, suitably trained and skilled staff.

Systems were in place to monitor the effectiveness of the service. The provider had engaged external consultants who undertook regular audits of the service and provided reports which highlighted areas where improvements could be made. Some internal audits were undertaken, although we did note that some of these needed to be more robust. For example, a monthly medicines audit was undertaken. For three consecutive months this was identifying similar concerns although it was not clear that robust measures had been taken to address these. Call bell audits were undertaken which demonstrated that staff were responded promptly to requests for assistance. A monthly weight loss and falls audit was also undertaken. The registered manager undertook unannounced checks at to provide reassurances that the support being provided to people was safe and effective.

The provider had a clear business plan which set out objectives for 2016. Many of these had already been

put in place or were underway. For example, plans were underway to implement the 'Personhood concept' based around person centred care. A refurbishment programme was underway to enhance the design and layout of the building for people living with dementia. A relative told us they "Liked the way the owners were re-investing in the building". Plans were also in place to strengthen links with the local community with a second activities co-ordinator employed to take the lead on this. The provider and registered manager told us it was important that people's care was provided in a manner which was in keeping with their values of 'Loving care' and that honesty, integrity, openness and teamwork were expected from all staff. Our observations indicated that staff and the registered manager acted in accordance with these values.