Syne Hills Care Home Limited

Syne Hills Care Home Limited

Inspection report

Syne Avenue
Skegness
Lincolnshire
PE25 3DJ

Tel: 01754764329
Website: www.synehills.co.uk

Date of inspection visit:
02 June 2016
07 June 2016

Date of publication:
21 November 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Syne Hills Care Home Limited on 2 and 7 June 2016. This was an unannounced inspection. The service provides care and support for up to 35 people. When we undertook our inspection there were 32 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks.

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

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect them. At the time of our inspection there one person subject to such an authorisation.

The staffing levels need to be monitored on a regular basis through a 24 hour period to ensure each person's needs are being met. Systems need to be reviewed to ensure staffing levels are adequate to meet people's needs.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe. However, attention to detail regarding possible infection control risks and thorough auditing checks need to be maintained to ensure the environment is safe and equipment is safe to use.

People were treated with kindness and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives. Staff had taken care in finding out what people wanted from their lives and had supported them in their choices. They had used family and friends as guides to obtain information.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home and quality checks had been completed to ensure services met people's requirements. New systems for auditing were in place and need time to be embedded and sustained to be thoroughly effective.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Sufficient staff were on duty to meet people's needs. However, this needs to be monitored regularly to ensure each person's needs are met through a 24 hour period.

Staff in the home knew how to recognise and report abuse.

Medicines were stored safely. Care must be taken to ensure records are accurately kept.

Thorough auditing checks need to be maintained to ensure there are no infection control risks and the environment is safe to live in.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Good

The service was responsive.

People's care was planned and reviewed on a regular basis with them.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Good

The service was well-led.

People were relaxed in the company of staff and told us staff were approachable.

Audits were undertaken to measure the delivery of care, treatment and support given to people against current guidance. However these needed to be embedded to ensure sustainability.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

Syne Hills Care Home Limited

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 2 & 7 June 2016 and was unannounced.

The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

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.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. During the inspection we spoke with a visiting health professional and an external staff trainer.

During our inspection, we spoke with 10 people who lived at the service, three relatives, two members of the care staff, a kitchen assistant, the deputy manager, the operations officer, a nutritional support care worker, administrator, an activities organiser, the housekeeper, the registered manager and one of the owners of

the home. We also observed how care and support was provided to people.

We looked at seven people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files and audit reports the registered manager had completed about the services provided.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. When entering the home there was a notice alerting people that the home was protected by CCTV. We saw there were cameras in place. This made people feel safe knowing the premises was being watched.

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by the home but were not all aware of other agencies and their role. They told us they were confident the manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health care professionals was recorded. There was a process in place for reviewing accidents and incidents on a regular basis. This ensured any changes to practice by staff or changes which had to be made to people's care plans was passed on to staff. Staff told us they were informed through shift handover periods when actions needed to be revised.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. For example, where people had problems walking due to their medical condition. Staff had asked the advice of other health care professionals to ensure each person was using the correct walking aid for them. We observed staff walking with people to ensure they were safe. This was a positive way forward for each individual to help them maintain their independence. Where people had a history of falls an assessment had been completed to see when this was more likely to occur. Staff had liaised with the NHS falls coordinator to see what measures could be put in place to protect each person. Staff had looked at options for each individual to ensure they could maintain their independence, but the risk of falls had been assessed to allow them to take risks.

Staff and people's records confirmed that assessments had taken place on the capability of people to visit the community either with an escort or on their own. Staff told us that some people would not remember how to get back to the home; so a member of staff escorted them on trips out or for health appointments. This was recorded in people's care plans.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help with walking due to poor sight. A plan identified to staff what they should do if utilities and other equipment failed. Staff knew how to access this document in the event of an emergency.

We saw two bedroom doors which had barriers across them. The rooms were occupied. One had a solid barrier which came up a third of the way of the door frame and the other was a rope barrier. Staff told us they were in place as people did not like people other than staff entering their rooms. This was not written in their care plans. There was also a rope barrier across the bottom of the main stair case. We did not see any

records to show that those types of barriers had been approved by the fire and rescue service. In the event of an evacuation of the building the barriers could hinder the evacuation of people. The operations manager contacted the local fire and rescue service during our visit to ask them to complete an assessment.

We were invited into six people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. They told us they were happy how their rooms were kept clean. We pointed out to the owner and operations manager a number of concerns we had regarding safety of the environment. These included floor covering in a bedroom which was a trip hazard, a fire extinguisher which was not wall mounted, a radiator cover which was not secured to the wall and had screws hanging out of the wood frame. The operations manager was going to task the maintenance person to repair all items identified to ensure they were safe. Only the fire extinguisher bracket had been repaired on our second day visit.

Staff told us key pad entry was the only way into the building. However, a relative demonstrated to us how they were able to enter the building using a quick release mechanism. A bell did sound in the home, but no staff member responded to that alarm and the relative and member of the inspection team freely entered the building. This was tested later the same day by the inspection team and there was still no response from staff.

There was hand sanitizer available at various points in the corridor and by the visitors signing in register. We saw some visitors and staff use this, but not all. There were some items on display and in use which posed an infection control hazard. These included some faeces on commode buckets which had been placed on a shelf in a clean equipment area, some waste bins in toilets and bathrooms did not have lids, the string light pull cords were dirty and did not have plastic covers. In one bathroom night wear of people had been hung on hooks behind a curtain. This was next to a toilet in that room. Staff told us they were placed there as it was convenient for staff when undressing people after tea, who liked to still stay in a sitting room. They were unaware of the risk of infection. We stopped a person entering the same bath room, who staff told us had memory problems, as we saw containers of a foam substance on an open shelf. The tops of those containers were easily depressed and foam fluid came out. We were told this was for "giving people a quick wash". This part of the room had a curtain attached to the shelf area, but this was not pulled across. We were informed this would be brought to the attention of the registered manager to make a decision on how to tackle each problem.

Some people told us their needs were being met, but others told us about times when they had to wait for care to be given to them. One person told us they had wanted to use a toilet at night, but that staff took a very long time to get to them. Another person said, "I just wish there were more carers." A relative who had been speaking to us about the night care their family member received said, "There are not enough carers at night on duty." People told us they felt hindered to be able to use the garden during the day. One relative said, "There are not enough carers to get [named relative] into the garden during the day."

We heard the call bells ringing for long periods of time. On one occasion we asked a staff member to show us where a certain part of the home was, as a call bell had been ringing for a long time. This was a long way from the hub of the home and the person was very agitated when we arrived as their chair had pushed them forward and they had broken a cup and saucer. Staff were very kind to the person. One person told us, "The bells do ring for a long while; the staff are really stretched most of the time." The person stated this when asked if there were enough staff on duty.

Staff told us that the staffing levels were stretched and that at certain times of the day it would be beneficial if more staff were available. One member of staff said, "There is enough staff on duty if everyone pulls their

weight but it would be good if they employed some people on short shifts so they can come to cover sickness, because we sometimes can't get cover." Another staff member said, "Staffing doesn't work at night. Everyone gets what they need but it's a struggle." Another staff member said, "All the staff work pretty good and are good enough to cover. People's needs are met I think." The provider needs to improve their systems to ensure there are enough staff to meet people's needs through a 24hour period.

Staff told us the staffing levels were calculated by a member of the administration staff. They did not know how the numbers were calculated. Contingency plans were in place for short term staff absences such as sickness and holidays. Gaps were filled by part-time staff working more hours. The registered manager told us they used their own formula for calculating staffing levels and reviewed as occupancy levels went up or down. A lack of staff during a 24 hour period could result in people not having their needs met.

We looked at two personnel files of staff. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. There were no current staff vacancies. However, there were photocopies of the Disclosure and Barring Service (DBS) safety check forms. Staff were seeking to find a different way in retaining the evidence required to ensure documents seen were actual records. The photocopies were destroyed during our visit.

People told us they received their medicines at the same time each day and understood why they had been prescribed them. One person said, "The staff have been very good with my medication." This had been explained by GPs', hospital staff and staff within the home. This was recorded in people's care plans. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in a locked area. There was good stock control. Records about people's medicines were accurately completed prior to the inspection. Medicines audits we saw were completed regularly. We saw the audit for May 2016 which indicated that identified actions had been signed as completed. The local pharmacy supplier had also completed an audit in September 2015. This was a positive outcome.

We observed medicines being administered at lunchtime. The staff member administered all medicines safely and stayed with each person until they had taken their medicines. However, they did not complete the administration records correctly. They were aware of their mistake. We also found that staff had not given one person their medicine in the morning and this had been stored in the medicine trolley, in an open container. It was not labelled. Staff were aware of their mistake and that any other staff member would not know who the medicine was for and why it had been left. We reported both incidents to the registered manager. The registered manager told us they would take suitable action with the staff member and review staff processes for administration of medicines.

Staff who administered medicines had received training. Reference material was available in the medicines storage area and staff told us they also used the internet or the local pharmacy for more detailed information about particular medicines and how it affected people's conditions.

Good

Is the service effective?

Our findings

A member of staff who had been recently recruited told us the process which had taken place for their employment to commence. This followed the provider's policy for induction of new staff. This included assessments to test their skills in such tasks as manual handling. This provided the skills they needed to meet people's needs safely. Details of the induction process were in the staff training files. Staff told us that the provider was helping them to complete the new care certificate. This would give everyone a new base line of information and training and ensure all staff had received a common induction process.

Staff said they had completed training in topics such as manual handling and fire. They told us training was always on offer and it helped them understand people's needs better. The training records supported their comments. Staff had also completed training in particular topics such as diabetes and autism spectrum disorder. This ensured staff had the relevant training to meet people's specific needs at this time. However, not all staff had completed their mandatory training, but the provider was aware which staff this involved. We saw this had been identified on the training planner for urgent attention. A visitor told us when asked about training of staff, "Some staff are not really interested, but here the staff are very keen."

Staff progress with their training was discussed at their supervision session and termed, continual professional development. Staff had opportunity to discuss their training needs and set up courses specifically for themselves. A staff member told us they had been encouraged to expand their knowledge about nutritional support for people and had attended a course on the topic.

Staff told us a system was in place to test their competences and that they received formal supervision each year. They told us that they could approach the registered manager at any time for advice and would receive help and supervision until they were competent in a task. The records showed when supervision sessions had taken place, which was in line with the provider's policy. There was a planner on display showing when the next formal sessions were due. Staff had received at least two formal supervision sessions in 2016.

The 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. We found that the provider had followed the requirements in the DoLS. One application had been made and staff had recorded when this was due for review. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. This included best interest meetings with all relevant parties and agencies.

People told us that the food was good and that it had recently improved since a new outside catering firm was supplying the meals. One person said, "[Named food company] food cannot be faulted." Another person said, "Good food, good choices." Another person said, "Everyday something different."

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet. The kitchen staff kept records on people's likes and dislikes. One member of staff told us, "The other day [named person] didn't like the choices so the kitchen cooked egg and chips." This ensured people received what they liked and what they needed to remain healthy. We saw staff had asked for the assistance of the hospital dietary team in assessing people's dietary needs. A newly appointed staff member monitored the nutritional needs of people. We saw them observing meals people were eating and recording in the care notes how the experience had gone. They offered support and suggestions to people on how to improve their dietary intake for their health and wellbeing. They recorded in the care notes when they had asked staff to continue monitoring people and we saw where staff had added their own notes.

A cycle of menus were available and on display within the kitchen area. The daily menu was on display on a notice board in the dining room. However, if people could not understand the written word there were no picture menus available to help them to remember or make clear choices.

We observed staff helping people with drinks throughout the day. This was to ensure they had an adequate intake of fluids. Some people had been assessed as not being able to monitor their fluid intake so staff recorded their intake of fluids on charts and reviewed this when required. We observed the lunchtime meal. People could sit where they liked. One person told us they preferred to have their meals in their bedroom, but sometimes used the dining room and their wishes were respected. We observed staff taking meals to people in their bedrooms. The plates and bowls were covered and staff ensured people were sitting comfortably before leaving them to eat.

We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. For example, people were being encouraged to complete some leg exercises. This was because they had been temporarily unable to walk due to some medical problems and were having to use a wheelchair to move around. We heard staff speaking with relatives about hospital appointments and GP appointments, after obtaining people's permission. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made.

People told us staff obtained the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people required checks such as eye and blood tests to monitor their medical condition. We also saw in the records when people had visited the opticians and dentist. Several of the people had hospital appointments which they had attended. Staff had recorded outcomes of those visits. Staff told us they had a good rapport with other health professionals and felt supported by them when they required assistance. A newly appointed staff member now attended the twice weekly surgery within the home held by visiting health professionals. This was beginning to be embedded into every day practice and was a new liaising role for that staff member.

Good

Is the service caring?

Our findings

People told us they were well cared for by staff. They said they were supported to make choices and their preferences were listened to. One person said, "They are a grand lot they do have patience with you." Another person said, "I call it my home." A relative told us, "In Syne Hills you are not alone, you have carers that really care for you on good and bad days." Another relative said, "The carers have patience, but it is tested a lot."

People were given choices throughout the day of, for example, where to sit, what activities they could take part in and how they wished to dress. Some people choose to stay in their bedrooms. One person said, "I'm quite content here in my room. I'm not a mixer." Another person was being encouraged to wear foot wear. Staff explained how important it was to wear appropriate good support to enable them to walk safely.

We observed care interactions which were kind, patient and sensitive to people's needs. Staff were patient with people when they were attending to their needs. For example, one person was concerned about the time of day so staff repeatedly told them and reminded the person that, for example, it was near to when a relative would visit. There was a lot of banter between people and staff.

We observed people were given information and explanation when they needed it for a variety of issues and concerns. This included information on pain relief medicines, times of GP appointments and results from previous tests. Staff explained the answers in terms people understood and ensured people knew exactly what staff had been talking about before leaving their presence.

When people were given information they were asked whether this could be given in a communal area or whether people needed privacy. People's views were respected. People made comments such as "My private business is always kept confidential" and "Staff know private means private for me."

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. However, we saw two people in their nightwear in the conservatory prior to tea time. Staff told us they liked to sit there, but preferred to wear their night clothes. There was nothing in their care plans to say this was their choice or to indicate whether other people who also used the conservatory liked the arrangement.

The provider had recruited a staff member to be what was termed a 'dignity champion'. The person monitored how staff behaved with people and if they preserved people's dignity at all times. The staff member had attended training courses on how to promote dignity and respect and had cascaded this down through the staff group.

People told us staff treated them with dignity and respect at all times and respected the choices they wished to make. One person said, "Staff respect what I want to do." Another person said, "I like sitting here, staff

don't ask me to move and know I like to observe people." A staff member told us when a sitting room was being redecorated samples of wall paper were put on display and people could make their choices. The majority vote meant that wall paper was chosen.

We observed staff knocking on doors prior to be given permission to enter a person's room. They asked each person's permission prior to commencing treatment. We observed staff ensuring people had suitable clothing on when going out of the building and sitting in communal areas.

People told us they could have visitors whenever they wished. We saw several signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us some families visited on a regular basis and they were offered refreshment and opportunity to speak with staff. This was recorded in the care plans. This ensured people could still have contact with their own families and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display. There were no local advocates being used by people at the moment.

Good

Is the service responsive?

Our findings

People told us staff had talked with them about their specific needs. This was in reviews about their care. They told us they were aware staff kept notes about them. People told us they were involved in the care plan process. However, there were no nationally recognised assessment tools in use for people who had a learning disability, impaired cognitive ability or other communication difficulties; such as those associated with dementia. This meant people may not understand their care plans if they did not understand written English, unless they were read to them. The care plans were on a computer data base, which was password protected and accessed on a need to know only basis by staff.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. We observed an afternoon handover. Important daily information was passed on and staff given time to ask questions for clarification.

People told us staff had the skills and understanding to look after them and knew about their values and beliefs. People told us that staff knew them well and how their beliefs could influence their decisions to receive care. Staff knew how to meet people's preferences with suggestions for additional ideas and support. This means people had a sense of wellbeing and quality of life. Staff had used local resources in health and social care to ensure messages were received by people about health matters.

People told us that staff took time each day to discuss their care and treatment. They also had the opportunity to speak with other health professionals. This was recorded in each care plan. For example being able to see a nurse or GP at the weekly medical sessions within the home.

Three of the care plans we reviewed were for people whose life was coming to an end. Staff had documented all visits and advice sought by other health care professionals. The Do Not Attempt Cardiac Resuscitation forms had been correctly completed by other medical practitioners except one. We informed the registered manager which form this was and they told us they would seek clarity from a health professional. Staff were aware of the importance of involving other health care professionals to establish resuscitation status.

Social and health care professionals we had contact with before, during and after the inspection told us staff informed them quickly of any issues. They were confident staff had the knowledge to follow instructions and did so. They told us they were given relevant referrals and enough information to make an accurate assessment of people's needs.

We were informed that an activities co-ordinator was employed and they were facilitating activities for people during our visit. People and relatives told us there was a lack of any meaningful physical stimulation and they would like more. By this they meant exercise and being able to go out of the building. However, the records showed people did have movement to music exercises and outings had taken place to local events, church events and visits shopping.

Any activities which had occurred in the last year were recorded in the care plans. This was mainly group events such as art sessions, games afternoons and entertainment. Staff told us no one had any current hobbies that they were involved in. The week's activities were on display in the reception area. Staff told us these could be varied depending on what people wished to do.

We observed some people playing dominoes and some completing some adult crayoning art. In the afternoon there was a visiting Tuck Shop where people could purchase small items such as sweets and toiletries. One person told us the Tuck Shop had visited them in their bedroom so they could make their choices. Another person told us, "I go to ten-pin bowling every Thursday". The provider assisted people to attend a regular Christian church service every Sunday, if they wished to go.

Staff had assisted two people in setting up a Facebook page so they could keep in touch with their friends. Staff had helped them to post pictures and set up a video chat, which people said they enjoyed.

We observed notices around the home to guide people who might have memory loss; either on their bedroom doors or to guide the way to other areas such as the dining room. We did observe staff directing people to those areas as well.

People told us that the provider always made sure when someone new arrived that they were made welcome. They were introduced to other people so they felt at home in their new home.

People are actively encouraged to give their views and raise concerns or complaints. People's feedback is valued and concerns discussed in an open and transparent way. People told us they were happy to make a complaint if necessary and felt their views would be respected. Each person knew how to make a complaint. No-one we spoke with had made a formal complaint since their admission. People told us they felt any complaint would be thoroughly investigated and the records confirmed this. We saw the complaints procedure on display.

The complaints log detailed the formal complaints the manager had dealt with since our last visit. It recorded the details of the investigations and the outcomes for the complainant. One complaint was still on going, but the registered manager had documented all processes to date.

Good

Is the service well-led?

Our findings

There was a registered manager in post. People told us they were well looked after, could express their views to the registered manager and felt their opinions were valued in the running of the home. One person said, "[Named registered manager] is very hands on." Another person said, "[Named staff member] is more like a trouble shooter, any problems [named staff member] will sort and get back to you."

People who lived at the home and relatives completed questionnaires about the quality of service being received. People told us they had completed questionnaires. The last questionnaire had been for the period January 2015 to May 2016 for people who used the service and was very positive. People made comments such as, "level of quality of care given was excellent" and "food improved."

Staff told us they worked well as a team and felt support by the registered manager. One staff member said, "I love them lots it's great." Another staff member said, "I enjoy my work and like this place. I'm a carer it's a way of life not a title."

Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of the staff meetings for October 2015, November 2015 and May 2016. The meetings had a variety of topics which staff had discussed, such as; training, safe guarding adults and themed events within the home. This ensured staff were kept up to date with events. Staff told us they felt included in the running of the home.

The registered manager and other managerial staff were seen walking around the home during our inspection. They talked with people who used the service and visitors. They could immediately recall items of information about each person. They gave support to staff when asked and checked on people's needs. Where necessary they also assisted with care related tasks; such as assisting someone with personal care and assisting someone into hospital ambulance transport.

There was evidence to show the registered manager had completed audits to test the quality of the service. A staff member had been employed to monitor the quality assurance audits. These included medicines and care plans. The infection control audit had not been completed since July 2013, but was in the process of being revised with help from health care professionals. Where actions were required these had been clearly identified and signed when completed. Any changes of practice required by staff were highlighted in staff meetings and shift handovers so staff were aware if lessons had to be learnt. The new staff roles within the home for measuring the quality of the services being provided were yet to be fully embedded and sustained and procedures were being altered as staff roles developed.

A member of staff observed care practices of staff to ensure people's needs were being met and people were looked after safely. The spot checks took place at different times of the day. We saw the ones documented, which had taken place in April 2016. These included quality assurance records, supervision records and complaints records. On this occasion no actions were required.

We could not see a copy of the recent CQC report on display, but were told this was available from the office. We saw a copy on display in a staff area. Parts of the provider's website were not up to date such as their Statement of Purpose, due to new staff recruitment and processes being in place. The registered manager was asked to send us the revised copy when completed.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The registered manager understood their responsibilities and knew of other resources they could use for advice, such as the internet and local multi-agencies.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.