Hayes Cottage Nursing Home Limited

Hayes Cottage Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on 4 and 5 July 2017 and the first day was unannounced. The last inspection took place on 13 October 2015 and was a focussed inspection at which we found the service had made the required improvements to address shortfalls identified at the previous comprehensive inspection.

Hayes Cottage Nursing Centre is a care home that provides nursing care. The home has a 10 bedded palliative care unit and two units for general nursing care which cater for people with a range of needs, including those associated with dementia. The service is registered for 52 beds and at the time of inspection there were 44 people using the service.

The service is required to have 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 2008 and associated Regulations about how the service is run. The manager joined the service in October 2016 and had submitted an application to the CQC to become the registered manager.

People, relatives and healthcare professionals were happy with the care and support being provided at the service. Systems were in place to safeguard people from the risk of abuse. Staff understood whistle blowing procedures and the action to take if they had any concerns. Risk assessments and action plans were in place to minimise risks to individuals. Systems and equipment in use were being monitored and serviced to maintain their safety.

Staff recruitment procedures were in place and being followed to ensure only suitable staff were employed by the service. There were enough staff on duty to meet people's needs and the service was managing short notice sickness and absenteeism appropriately. Staff received training to provide them with the skills and knowledge to care for people effectively. The provider made suitable arrangements to ensure people were protected against the risks associated with the inappropriate management of medicines.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). Authorisations under DoLS were in place where required to ensure that people's freedom was not unduly restricted. Staff understood people's needs and acted in their best interests.

People's dietary needs and preferences were being identified and met. People's nutritional needs and status were assessed and monitored. Their healthcare needs were identified and they received input from healthcare professionals when required.

People were consulted about the care and support they wanted to receive and encouraged to make decisions about their care, which staff respected. Staff were polite and respectful and cared for people in a kind and friendly way. End of life care was planned involving people and their relatives and was provided in

a caring and compassionate way.

Care records were personalised and up to date. Any changes in people's condition were identified and recorded and staff read the care records so they had an up to date picture of people's needs. The service had a varied activities programme and strived to provide activities to meet people's interests and needs. There was a complaints procedure in place and this was followed. People and relatives were able to raise any concerns they had and felt the service addressed them.

The manager was approachable and visible throughout the service, so people, relatives and staff knew who they were and felt able to approach them. People, relatives and staff spoke of the provider and the management team in a positive way and were able to give their opinions about the service provided and action was taken to address issues raised.

The provider had identified improvements were needed to the environment, and had arranged for these to take place to improve the experiences of people living at the service. Systems for monitoring the service were in place and identified any shortfalls. Action was taken to address any issues so that monitoring processes were implemented effectively.

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.

Systems were in place to safeguard people from the risk of abuse. Staff understood whistle blowing procedures and the action to take if they had any concerns.

Risk assessments and action plans were in place to minimise risks to individuals. Systems and equipment in use were being monitored and serviced to maintain their safety.

Staff recruitment procedures were in place and being followed to ensure only suitable staff were employed by the service. There were enough staff on duty to meet people's needs and the service was managing short notice sickness and absenteeism appropriately.

The provider made suitable arrangements to ensure people were protected against the risks associated with the inappropriate treatment of medicines.

Is the service effective?

Good

The service was effective.

Staff received training to provide them with the skills and knowledge to care for people effectively.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). Authorisations under DoLS were in place to ensure that people's freedom was not unduly restricted. Staff understood people's needs and acted in their best interests.

People's dietary needs and preferences were identified and met. People's nutritional needs and status were assessed and monitored.

People's healthcare needs were identified and they received input from healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People, relatives and healthcare professionals spoken with were happy with the care and support being provided at the service.

People were consulted about the care and support they wanted to receive and encouraged to make decisions about their care, which staff respected. Staff were polite and respectful and cared for people in a kind and friendly way.

End of life care was planned involving people and their relatives and was provided in a caring and compassionate way.

Is the service responsive?

Good

The service was responsive.

Care records were personalised and up to date. Any changes in people's condition were identified and recorded and staff read the care records so they had an up to date picture of people's needs.

The service had a varied activities programme and strived to provide activities to meet people's interests and needs.

There was a complaints procedure in place and this was followed. People and relatives were able to raise any concerns they had and felt the service addressed them.

Is the service well-led?

Good

The service was well led.

The manager was approachable and visible throughout the service, so people, relatives and staff knew who they were and felt able to approach them. People, relatives and staff spoke of the provider and the management team in a positive way and were able to give their opinions and action was taken to address issues raised.

The provider had identified improvements needed to the environment, which were taking place to improve the experience of people living at the service.

Systems for monitoring the service were in place and identified any shortfalls. Action was taken to address any issues so that monitoring processes were implemented effectively.

Hayes Cottage Care Centre

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.

The inspection was carried out on 4 and 5 July 2017 and the first day was unannounced. The inspection was carried out by one inspector, a specialist advisor in medicines management 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.

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 also reviewed the information we held about the service including notifications and information received from the local authority. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

During the inspection we viewed a variety of records including six people's care records, thirty six medicines administration record charts, six staff recruitment records, staff training records, servicing and maintenance records, risk assessments, audit reports and policies and procedures. We used the Short Observational Framework for Inspection (SOFI) during lunchtime in the dining room. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interaction between people using the service and staff throughout the inspection.

We spoke with sixteen people using the service, five relatives, the manager, the nominated individual, the finance director, the deputy manager, the HR manager, three registered nurses, two senior carers, a carer, the liaison officer, the activities coordinator, the chef, the administrator, the maintenance person and two healthcare professionals.

Good

Is the service safe?

Our findings

Safeguarding procedures were in place and these were being followed to protect people from the risk of abuse. Staff had received training in safeguarding, understood the procedures and knew to report any concerns to their line manager and record the incident. We gave staff scenarios and they were clear on the process to follow, including whistleblowing procedures to report outside the service if necessary. Staff comments included, "I would whistle blow if necessary to CQC, Hillingdon or even the police if necessary" and "I know what to do to report to safeguarding or whistle blow and feel confident to do this." The manager knew to report any safeguarding concerns to the local authority and to the Care Quality Commission (CQC). Where safeguarding investigations had identified shortfalls, action had been taken to address them. For example, following one investigation improvements had been made in the monitoring of pressure relieving equipment.

Risks were assessed and action taken to minimise them and maintain people's safety. We asked staff how they kept people safe. Comments included, "Be aware of safety constantly, make sure [wheelchair] seat belts and brakes are secure. Remind residents and staff about these, for example, not to lean out of chairs. Keep people engaged, cared for and know about their individual needs" and "We have training and I make sure I know all about the residents. If I don't I read their plan or ask someone." Each person had risk assessments to address individual areas of risk, for example, risk of falls, wandering, use of bedrails and wheelchair lap straps and of development of pressure ulcers. Care plans recorded the action to be taken to minimise each risk. Risk assessments for safe working practices were also in place to include equipment in use such as kitchen and laundry equipment. The weather was warm and fans were in use for people in their bedrooms. These were placed on flat surfaces and the manager completed a risk assessment for their use to identify risks and the action to minimise them. The fire risk assessment had last been completed in April 2017 and an action plan was in place to address the findings which had been classed as low risk.

The service was being maintained to keep people safe. We sampled servicing and maintenance records and saw that equipment such as the fire alarm was being serviced at the required intervals. The fire alarm was tested each week and fire drills took place to include day and night staff. These were recorded with outcomes and demonstrated staff followed fire drill procedures. Staff confirmed the drills took place and that they had also received training in fire safety. The service had a development plan for redecoration and refurbishment and they had identified two rooms on the first floor that were being converted into a sitting room for people as there was no such facility at present. We saw ground floor corridors had been redecorated and flooring was being upgraded and work was ongoing to improve the environment for people to live in. The service had a business continuity plan and procedures for major events such as flooding, fire and major power failures and this identified nearby large buildings to be used for refuge, so people could be kept safe.

Recruitment procedures were in place and being followed so only suitable staff were employed by the service. Prospective staff completed an application form and a medical questionnaire. The service took up references including from the recorded last employer, carried out a Disclosure and Barring Service (DBS) check, obtained a photograph and proof of identity and confirmed the person's right to work in the UK. Any

gaps in employment were discussed and interview notes were completed to evidence the discussions. Staff confirmed that when they had applied to work at the service the recruitment process had been followed. The service had recently employed an experienced Human Resources (HR) manager and they were clear about the recruitment process to be followed and their responsibilities to ensure staff employed were suitable to work with people who use the service.

During the inspection there were enough staff on duty to meet people's needs. People confirmed that call bells were answered in a timely way and we observed staff respond promptly to requests for assistance. The provider was aware of times, often at weekends, when due to short notice absence the service had been short of staff. Action had been taken to attempt to cover the shifts, however, due to the very short notice given on occasion this had not always been possible. Staff commented that there were sometimes shortages at the weekend but also that action was taken to address this. CQC had also received some concerns regarding staff shortages and the provider had responded to the issue with an action plan which highlighted the actions being taken to manage sickness and absenteeism. At the time of the inspection the provider was recruiting staff to fill the vacancies to resolve the shortage of staff over the weekend. To prevent this from happening again in the future, the provider had a programme of ongoing recruitment. The manager told us they carried out performance reviews with staff and was working with the HR manager to manage staff absence effectively.

Medicines were being managed safely at the service and people received their medicines as prescribed. We asked people about their medicines. Comments included, "The nurses help me and they tell me why I need it", "I have my medicine just after mealtimes and it is always on time. I know why I take it" and "They remind me to take it and watch me. They write it in my folder and they tell me what the medicine is. They remind me." Relatives were also satisfied with the medicines management at the service. Registered nurses were responsible for the administration of medicines on two, sometimes all three units during the day and on all units at night and for controlled drugs. On one unit senior carers had been employed, trained up and assessed as competent to administer medicines and were doing so during the day. There was a policy in place for this and the registered nurses retained responsibility to ensure all medicines were administered as prescribed.

The Medicines Administration Records (MAR) were complete and up to date and any allergies were recorded to prevent the risk of inappropriate prescribing. The only gap in signing was for someone who was feeling unwell and their morning medicines had been omitted while advice was sought from the general practitioner (GP). Where someone self-administered some of their medicines there was a completed assessment to determine that this was safe. We counted 15 random samples of supplies of medicines and could reconcile all with the records of receipts, administration and disposal.

We noted from the MAR, GP record sheets, a palliative care consultant and correspondence from hospital that medicines were reviewed regularly and dosage changes were documented. Some people were prescribed high risk drugs which needed regular blood monitoring. Dates and results of blood tests were kept with the MAR and records showed that these were administered as prescribed. If people were prescribed medicines to be given as required (PRN), protocols were in place so staff knew when and how often these should be given and a separate record was made on the back of the MAR. When a variable dose was prescribed the dose given was accurately recorded so the prescriber could determine the effectiveness. People had assessments to identify whether they were in pain and these were kept with their MAR and were regularly reviewed.

Where people had a percutaneous endoscopic gastrostomy tube (PEG- a special tube inserted directly into a person's stomach to help with feeding and hydration) to administer food and medicines, there were

protocols and records to monitor their fluid intake, tube flushes and tube maintenance. In cases where people had their medicines crushed and given covertly, this was agreed with the person's next of kin and healthcare professionals as being in their best interests.

Medicines were stored safely in locked clinical rooms and trolleys. Temperatures were recorded daily in the clinical rooms and for the medicines fridge so the potency of the medicines could be maintained. Controlled drug records were accurate and regularly checked. There were up to date medicines policies and procedures and we saw records of recent medicines training, palliative care training and PEG training. We viewed daily MAR checks and monthly medicines audits for the last three months and action taken to address any shortfalls identified was recorded. During a medicines round we observed that the registered nurse explained what people's medicines were and what they were for. They encouraged people to take their medicines, giving them time to do so and on leaving the person they made a record on the MARs. The medicines trolley was locked when not attended by the nurse.

Advanced care plans were in place with protocols for giving medicines via a syringe driver at the appropriate time for people receiving end of life care. There were detailed PRN protocols for medicines prescribed to control sickness and other symptoms which could develop. There was evidence of frequent reviews by the palliative care consultant and the GP. Medicines used in syringe drivers were all signed and checked by the prescriber. Syringe drivers owned by the service were regularly checked and re calibrated to ensure they were accurate.

Good

Is the service effective?

Our findings

We asked people and relatives if they felt staff were well trained. Their comments included, "They do know what they are doing and are very good", "I think they are very well trained and they are confident so they make me feel safe", "They know what they are doing here, there is no messing about they do it quickly and very well", "The staff are excellent and try to be very efficient. I feel confident leaving [relative] in their hands" and "You can't fault them they are excellent."

Staff received training to provide them with the skills and knowledge to care for people effectively. Staff confirmed they completed induction training and completed induction booklets were in staff files. Staff we spoke with felt they received a good amount of training and enjoyed learning. Their comments included, "Definitely I feel well trained, experienced and supported. I attend 'Falls Champions' training monthly", "I have regular training – e-learning and at Hillingdon for palliative training. I have had lots of training in the past year including tissue viability and end of life" and "I have regular training and am encouraged to keep up to date and enhance my skills."

The provider had introduced online training for all staff in twelve topics identified as mandatory by the provider, which included safeguarding, mental capacity and deprivation of liberty safeguards, fire safety, moving and handling, equality and diversity and health and safety. Staff also undertook practical training sessions in safe moving and handling of people for nursing and care staff and manual handling for non-care staff. Staff attended training sessions for specific topics such as end of life care and tissue viability (skin care). The home had two 'Falls Champions' who were attending a falls management course run by the local authority.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw that mental capacity assessments had been carried out and where people were identified as not having capacity, best interests assessments had also been completed. The provider had made appropriate applications under DoLS for people who might have been deprived of their liberty. We noted that care plans for mental capacity and to address any restrictions of peoples' liberty were in place and were comprehensive. Staff had received training in MCA and DoLS, understood people's rights to make choices and the importance of making decisions in people's best interests. One told us, "I understand that everyone is individual with rights and everyone is to be safe and treated equally." The manager was knowledgeable around MCA and DoLS and highlighted the importance of ensuring this was managed for everyone

effectively and in a timely way. People were able to move around the service and we saw some people going in and out of the care home without any restrictions. The office staff were aware who was able to go out unaccompanied, so they could ensure people were kept safe while respecting their rights.

People received the food and drink they needed to meet their nutritional needs. People's nutritional needs had been assessed and any dietary needs were identified. For example, if people required a pureed diet, this was provided. Where people had swallowing problems these had been identified and referrals made to the speech and language therapist (SALT). People were weighed each month and if concerns were identified with changes in weight the nursing staff would refer them to the dietitian for input. The manager monitored the monthly weights and knew who had been referred to the dietitian. The chef said they were kept informed of people's dietary needs and were given copies of any special instructions, for example, from the dietitian or SALT. Action was taken during the inspection to review a person's dietary needs by reviewing their meal consistency requirements and referring them for a SALT assessment. Food and fluid charts were in place and being completed for people whose intake needed to be monitored.

Drinks were available and we saw staff encouraging people with these. People confirmed this and their comments included, "They put a jug next to the bed at night and a thermos with tea", "There are always drinks available. They come round all the time and they said I can help myself in the conservatory" and "I help myself in the lounge or my room if I can. If not they make sure I get enough and can always reach a drink." A relative told us, "There is always a drink in her room within reach and they come and give it to her regularly."

We asked people if they got healthcare input. They told us, "I tell them [staff] and they call them [my GP] in. The nurse will have a look at you first but usually you wait up to a day", "All my appointments are arranged for me and I have seen the optician and dentist since I moved here already" and "Everything is sorted out for me and they remind me on the morning if someone is coming in." A relative said, "It has been very well organised and they keep us informed if any professionals are coming in to see her and will give us a call to tell us the time." Healthcare professionals we spoke with confirmed people were referred to them appropriately for input and staff were available to assist and were able to tell them about the person's medical conditions. We saw in people's care records that they received healthcare input from a range of professionals including the GP, palliative care consultant, psychologist, dietitian, SALT, podiatrist and tissue viability nurse specialist. Staff had received training in first aid and if people were unwell staff knew to refer them either to the GP or, if the situation required it, to call the emergency services to assist the person.

Good

Is the service caring?

Our findings

People and relatives confirmed staff were caring. Comments included, "They are very caring. If you're feeling a bit low there is always someone to give you a hug or hold your hand or make you laugh", "They are really nice and when I came here they were very reassuring and kind", "They are lovely people down here. I can't fault them and they are very kind to me and to my family", "They show they care about the family and visitors as well as the residents" and "They are lovely and they make me feel I am welcome whenever I would like to be here." Throughout the service there was a homely, welcoming feel and we heard laughter and conversation between people and staff in communal areas and bedrooms. Staff knocked on people's doors before entering and spoke with people in a polite and friendly way, listening to what they had to say.

We asked people and relatives about staff respect for privacy and dignity and they said, "I get all the privacy I need whenever I want it. They knock on the door and call out who it is. I can lock the door but I choose not to and they wait outside the bathroom and ask me before they come in if I finished", "You get as much privacy as you want here. They let me make choices all the time and I still manage my life how I like", "They really do respect your privacy and especially as a family. They don't intrude unless they really have to do so" and "When we are not here they leave the door open to her room so she can hear people and when we are all here they give us the privacy we need to be with her." People also felt they could speak to staff in confidence and that this was respected. One person said, "They are very discreet and they record everything. If you need to chat they shut your door and make sure no one is around so you can talk in privacy" and another told us, "I know I can speak with them any time about anything and they won't spread it around. It is all very private and confidential."

People were able to make choices about their care. Comments included, "They choose how they spend their day, choices are discussed", "People can choose if they want assistance or where they spend their day. People can choose who looks after them, male or female carers", "People can choose carers they like" and "They choose where they want to spend their time, for example activities room, lounge, outside." Staff confirmed people could make choices about having their door open or closed. We saw in the care records people's preferences were recorded, for example, food likes and dislikes, waking and retiring times and their preferred term of address, which we heard staff using.

People said they received care when they wanted it. Comments included, "I have a shower but I know I can have either [shower or bath] and one or more a week. I can get up when I want to", "I have a bath, I prefer it as I don't want to ruin my hair. They help me and it's once or twice a week. They help me to have a good wash on the other days and brush my hair" and "They help me with showers and they let me do what I can myself. I can go to bed when I like and get up at any time. I just press the bell for assistance. They don't rush me." Two relatives told us, "They have kept him very clean and ask him each time they wash him if they can" and "They don't make her do anything she doesn't want to do and they have kept her clean and well groomed."

People were happy with the food provision at the service. Comments included, "It is very nice and you get choices, they come round in the morning and tell you what they are offering", "The choices are good and

they do offer alternatives like baked potatoes, omelettes, sandwiches. They ask you around an hour or so before. I eat wherever I like but usually in the dining room", "They offer to cut things for me and when I felt ill they helped me to eat my soup. They were very kind" and "I can choose from a few things and it isn't bad. I eat in the garden, dining room, lounge. Anywhere really."

We observed the lunchtime experience in the dining room and for people in their rooms. One person did not like the meal and staff were swift to offer an alternative and people were also offered second helpings. On the first floor we saw several people who had their meals in their rooms. Staff members sat beside them to assist and the meal was positioned in front of people so they could view it. Condiments were provided and staff explained what the meal was and asked people if they were happy with it. People were given time to eat and drinks were offered during the meal. Staff chatted with people throughout the mealtime and it was relaxed and unhurried. People could choose if they wanted to eat in the dining room or elsewhere in the service.

All the staff we asked said they would be happy to have a relative or friend cared for at the service. We asked staff what was important to them when caring for people. Comments included, "Kindness and caring for each individual", "To listen to them and know about their needs. Keeping them safe and clean and looked after, doing my best", "They need the best from us – care, time, love, respect, and dignity" and "The individual – everyone is different." Staff understood the importance of people being able to make choices about how they spend their day and respected people's individual wishes.

We asked people if staff respected their religious and cultural needs. Comments included, "Yes I think they are, they listen to my feelings and often record what I would like", "My spiritual beliefs are respected here and recorded in my file" and "My wishes for how I spend my life and my time is recorded and they respect that and listen to me." We also asked staff about this. One said, "Yes we do and we expect everyone here and observe their routines, religion, culture. We have the same for staff too." Another told us, "We have two churches visit, usually weekly, Catholic and Baptist and every religion is respected." The chef said no-one currently at the service had cultural dietary requirements but that people's choices and any special dietary requirements were discussed and met and dietary preference forms were completed when people came to the service.

People living in the palliative care unit were receiving good end of life care. Feedback from relatives and people was positive and they felt their family members were receiving a good quality of care. A person commented, "They chat to me all the time about the care and what I would like, for example, my end of life, if I get ill where would I like to be. They write it in the care plan." One relative told us, "They have recorded [person's] end-of-life wishes and are respecting them." The staff demonstrated a good understanding of people's needs and how to meet them. There was a relatives' room and this was homely and provided relatives with a place to rest. Relatives were able to stay with their family member at all times if they so wished. The palliative care consultant from the Hillingdon Community Care Trust visited the service every week and at additional times when required and the service also had support from the hospice palliative care team when required. Advanced care plans for end of life were completed and those viewed were comprehensive and reflected people's wishes.

Good

Is the service responsive?

Our findings

People confirmed they knew about their care records, that staff listened to them and any changes in care and support needs were recorded. Comments included, "I have a care plan and we talk about what is in it and anything I would like to add", "They read my care plan and keep up-to-date with it. They also asked me questions", "They are very good at listening to me and updating the information in my folder. I get to tell them how I like things done and they write it down. They do ask me if they can help me with things like washing and dressing, going to the toilet." A relative said, "They are always updating information and they keep us up-to-date too and ask lots of questions." Another commented, "They ask questions and they prepare paperwork quickly so everyone knows what's going on."

There was information available about each person's needs and wishes so that staff could read the information and understand the care and support people required. The service was in the process of transferring care records onto a computerised records system and staff had received training in using this system, so they knew how to use it to input and update the information. The care plans we viewed were person-centred, comprehensive and provided a good picture of each person, their needs and wishes and how these were to be met. People and, where appropriate, relatives were involved with the care records and signed to agree to them.

Staff confirmed they read the care plans so that they knew the care and support each person required. Their comments included, "We chat with people and relatives and ensure care plans are detailed and up to date", "I keep up to date and make time for this" and "I do [read the care plans] and I try to keep on top of any updates, for example after a physio appointment."

We asked people if there were enough activities taking place. We received mixed comments that included, "I like group activities like singing, dancing and quizzes. We go on outings and I like the fish and chip days. You can have visitors whenever you want to.", "I'm happy to watch activities and I do like the film afternoons. It would be nice to do a few more things in my room like sewing or art work", "They have a big activity board by the dining room and also they remind us at breakfast and through the day what is going on", "I do a lot of sitting around waiting and they could be a few more activities. We did go out and it was nice and well planned" and "There isn't an awful lot going on but I do like to sit in the garden and the carers do make time to have chats with you." The surveys the service had carried out had also received a mixed response regarding activities and improvements were already being identified to better meet people's individual needs.

The home employed an activities coordinator and we asked how they identified people's interests. They told us, "I ask them, we sit and have a cuppa and talk about things we would all like. I can do one-to-one for this too." A varied activities programme was displayed on a board placed at accessible height for both people walking and those in wheelchairs to read. We saw people taking part in activities during the inspection and they told us they enjoyed these. One to one sessions took place with people who either by choice or the fact they were in bed, stayed in their rooms.

We observed a group activity in the garden and people were joining in and enjoying themselves. The activities coordinator led the activity and care staff were also on hand to assist. In the conservatory a painting activity took place and people were quietly getting on and content with what they were doing. The service also had a liaison officer who was involved with people's care such as hospital visits, outings and holidays. They also helped facilitate advocacy services and meeting individual requests for activities. They were organising the Summer Fair for later in the month and said this brought together people, relatives and the local community and raised funds for outings and events.

People and relatives told us they knew how to raise concerns and complaints. Comments included, "Definitely the manager because I know it would be dealt with straightaway. I send them a note and they get back to you the same day if they can", "I will tell any of them and they help to get things sorted out. I've never had a big complaint but if I did I would tell the manager", "Definitely the management they are very good and deal with things fast" and "I complained about medication and [nurse] made time to come and chat with us and explain everything straight away. It was very good and well-managed."

The service had a complaints procedure and this was displayed in the reception area. Staff were aware of the complaints procedure and were clear to refer people and visitors to the nurses or manager if they had any concerns. One member of staff said, "Refer them to the nurse or manager or record it myself and then tell them you will tell the manager." We viewed the complaints file and saw that complaints had been recorded, investigated and responded to in a timely way.

Good

Is the service well-led?

Our findings

We asked people their thoughts about the management of the service. Comments included, "She is a very nice lady and there is no messing around, she gets things done", "I do think I can talk to her about anything and she told me I can go to the office any time to chat with her or to leave her a message. She always gets back to you" and "She is new at being the manager and we all know her. She's always around. She is very good and quick at getting things sorted out. You see her helping out all the time." Relatives told us, "I do like her she's been really helpful and sensitive. They have gone out of their way to make us comfortable here" and "I do know the manager, she pops in to say hello. You see her around all the time and she's very approachable. I would say she is proactive."

People confirmed there were meetings and they could express their views. One person told us, "We have meetings where we sit around the table and have a cup of tea and chat about things like menus. They ask us what we would like and would not like to eat and things to do like activities." We saw minutes from meetings with people using the service and for relatives. These were clear and there was also an action plan for each meeting that recorded when issues raised had been addressed, for example, displaying the names of people's key workers had been requested and this had been done so people and relatives knew who they were. Regular staff meetings also took place including heads of department, night staff, day staff, catering staff and nurses and again we saw that the minutes of these contained action plans that had been signed off when completed.

Surveys had been completed for people, relatives, staff and stakeholders in June 2017 to get their views about the quality of the service. The results had been collated and action plans drawn up to address each question where 100% satisfaction had not been achieved and also any comments that identified an area for improvement. There was a timescale for completion of each action point and the management told us they were committed to continually improving the service, in both the care and support of people and the environment. We saw on display examples of 'what you told us, and what we did about it' on the quality assurance notice board, so everyone could see the results and what action was being taken to address points raised.

We also asked staff their views on the way the service was being managed. Comments included, "[Manager] is very nice and very helpful. I think she is treating everyone the same. She listens to everyone and solves problems", "The directors are very hands-on and assist with whatever you need, the manager also. Senior carers have been really helpful and supporting me while I am learning about each resident", "[Manager] is very hard working and on the floor, proactive, caring, sensitive and approachable. They are all very good and the directors are kind and supportive" and "The management are very easy to work with."

The manager was an experienced nurse and manager and had a recognised management qualification. The manager and provider were receptive and responsive during the inspection and took action to address any issues raised without delay. The management structure for the service had been reviewed and where areas had been identified for improvement, action had been taken to address this. For example, employing an HR manager to improve staff recruitment and retention and involvement from the tissue viability nurse to

review and advise on people's skin care. A non-clinical deputy manager was recently in post and the manager explained they had also employed a clinical deputy manager who would be starting in the next few weeks. The management structure was clear and staff understood this and appreciated the help and support they received.

There was an auditing system in place to monitor each area of the service and identify areas for improvement. Monthly audits included equipment, care records, the environment, health and safety and accidents. Action plans were in place for issues identified and these were signed off once the issue had been addressed. Policies and procedures had been updated within the last year and where appropriate referred to current legislation and good practice guidance. New staff were given time to read through policies and procedures and signed to confirm they had read these. Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required to monitor the service.