Weyspring Limited

Weyspring Park

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 4 December 2018 and was unannounced. This was the first inspection of Weyspring Park since it was registered by the Care Quality Commission (CQC) on 14 December 2017. New services are assessed to check they are likely to be safe, effective, caring, responsive and well-led when registering.

Weyspring Park is registered to provide nursing care and residential care for up to 24 people with a range of care needs, including frailty of old age, people living with dementia and mental health conditions. At the time of our inspection, 15 people were accommodated at the home. Weyspring Park is divided into three areas, over three floors with communal areas available to every person. Weyspring Park is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

A registered manager was in post. A registered manager is a person who has registered with the CQC 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.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. Background checks had been completed before care staff and nursing staff had been appointed. People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. Care staff had been supported to deliver care in line with current best practice guidance. People enjoyed their meals and were supported to eat and drink enough to maintain a balanced diet. People had been enabled to receive coordinated and person-centred care when they used or moved between different services. As part of this, people had been supported to live healthier lives by having suitable access to healthcare services so that they received on-going healthcare support. People had benefited from the accommodation being adapted, designed and decorated in a way that met their needs and expectations.

People were treated with kindness, respect and compassion and they were given emotional support when needed. They were supported to express their views and be actively involved in making decisions about their care as far as possible. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Confidential information was kept private. People received personalised care that was

responsive to their needs. People's concerns and complaints were listened and responded to in order to improve the quality of care. Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

There was a positive culture in the service that was open, inclusive and focused upon achieving good outcomes for people. People benefited from there being a management framework to ensure that staff understood their responsibilities so that risks and regulatory requirements were met. The views of people who lived in the service, relatives and staff had been gathered and acted on to shape any improvements that were made. Quality checks had been completed to ensure people benefited from the service being able to quickly put problems right and to innovate so that people consistently received safe care. Good team work was promoted and staff were supported to speak out if they had any concerns about people not being treated in the right way. The management team worked in partnership with other agencies to support the development of joined-up care.

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.

Staff had been trained to recognise the signs of potential abuse and knew what action to take.

Risks to people were identified, assessed and managed safely.

Sufficient numbers of suitable staff were employed and deployed to support people.

Medicines were safely managed.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Is the service effective?

Good

The service was effective.

People were supported by staff that had the necessary skills and knowledge to meet their needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

People received coordinated care when they used different services and they had received on-going healthcare support.

The accommodation was adapted, designed and decorated to meet people's needs and expectations.

People's care was provided in line with the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion and they were given emotional support when needed.

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

People's privacy, dignity and independence were respected and promoted.

Confidential information was kept private.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

People had access to activities that were important and relevant to them.

People's concerns and complaints were listened and responded to improve the quality of care.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Good

The service was well led.

There was an open culture and people benefited from staff understanding their responsibilities so that risks and regulatory requirements were met.

People who used the service, their relatives and staff were engaged and involved in making improvements.

There were suitable arrangements to enable the service to learn, innovate and maintain its sustainability.

Quality checks had been completed and the service worked in partnership with other agencies.

Weyspring Park

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 4 December 2018 and was unannounced. The inspection team consisted of two inspectors' and one 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. Their area of expertise was older person services and dementia care.

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 any improvements they plan to make. We reviewed information we held about the service, including safeguarding concerns shared with us from the local authority and notifications of significant events the provider sent to us. Notifications are events that the provider is required by law to inform us of.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We spent time observing care to help us understand the experiences of people who could not talk with us. We observed people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the lunchtime meal, medicines administration and activities.

We spoke with six people who lived in the service and with one visiting relative. We spoke with the registered manager and deputy manager who are both registered nurses and the administrator. We also spoke with one member of care staff, the chef and the maintenance contractor.

We looked at the care plans and associated records for four people. We looked at four people's medication records. We reviewed other records, including staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, complaint records, policies and procedures and external and internal audits. Records for three staff were reviewed, which included checks on newly appointed staff and staff

supervision records.

Good

Is the service safe?

Our findings

Without exception people we spoke with, who were able, told us they felt safe. Our observations confirmed people who were unable to initiate communication were asked throughout our visit if they were comfortable. Staff confirmed that people who appeared upset or not their usual selves were checked to see if they were in pain or needed assistance, which we observed.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed care staff had completed training and had received guidance in how to protect people from abuse and this was included in the induction for newly appointed staff. We found that care staff knew how to recognise and report abuse so that they could act if they were concerned that a person was at risk. One nurse told us, "If I think something is not right I can raise concerns." Staff informed us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm.

Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. This included measures that had been taken to help people avoid preventable accidents. We saw that hot water was temperature controlled and radiators were guarded to reduce the risk of scalds and burns. People were provided with equipment such as walking frames and raised toilet seats to reduce the risk of falls.

Risks to people had been assessed in areas including mental and physical health, alcohol abuse, self-neglect, absconding, noncompliance with medicines and self-harm. Two members of staff explained to us the missing person's procedure for a person who had been assessed at high risk of absconding and needed to stay at the home for their safety. Both staff members knew the person was on 15-minute observations during the day and knew the process to follow if the person was not found during an observation. Where people had risks such as choking, they had care plans, which detailed how their safety was to be ensured. For example, a person had a care plan which documented they tended to put large food items in their mouth and could be at risk because of this. Their care plan documented actions staff were to take to reduce this risk. We observed that staff followed this care plan. Moving and handling assessments gave staff clear guidance on how to support people when moving them. We observed staff communicating with people during transfers to check people felt safe and comfortable. We noted suitable equipment such as hoists and wheelchairs were available for staff to use and each sling was for one person's use only.

The premises were purpose built and the layout was such that it did not present significant difficulties in evacuating people in the event of an emergency. People had individual Personal Emergency Evacuation Plans (PEEP) in place on how they should be supported to evacuate the building in the event of a fire. Procedures were in place to keep the environment safe for people. An environmental risk assessment was in place which identified risks to people, staff and visitors. Daily, weekly and monthly health and safety checks were carried out. Fire drills took place and equipment such as fire, electrical, moving and handling equipment was serviced and fit for purpose. Risks for premises and equipment had been assessed and managed. Checks such as electrical wiring and Legionella had been carried out. The lift had been serviced.

Rescue mats were by stairwells and fire extinguishers available throughout the home had been serviced. Staff knew of the fire safety policy and procedure. Fire drills were carried out with staff and fire scenario training was carried out by night staff, fire alarms were tested each week and emergency lighting were tested monthly. Equipment such as hoists were serviced regularly to ensure they were safe to use.

Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs and preferences. Rotas for the week preceding the inspection showed staffing levels had been consistently maintained. At the time of our visit, there were five care staff in the building from 8am to 8pm. With one registered nurse on site to oversee the clinical needs of individuals. The registered manager was a registered nurse who also supported the clinical needs of the service.

The registered manager told us if agency staff were needed, they were allocated from an approved list. To ensure people were supported safely, we were told, they requested specific agency staff who knew the home to cover shifts and records confirmed this. Records confirmed that agency staff received an induction when first working at the home and given sufficient information about people who lived at the home to provide safe care. This included information about moving and handling and eating and drinking.

In addition to the care staff, the service had a team of housekeeping staff, one chef and one activity assistant on each day. The activity assistant supported the care staff with the dining experience of people. This enabled the care staff to attend to people and their needs. During our visit we observed people receive care and support in a timely fashion and call bells were responded to promptly. We observed staff having time to interact with people positively.

Recruitment practices were robust. Staff files showed references were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. Checks were made that nurses were registered with the Nursing and Midwifery Council (NMC). There were records to show staff were interviewed to check their suitability to work in a care setting.

The necessary arrangements had been made to ensure the proper and safe use of medicines. We observed a medicine round at lunch time and saw this was carried out safely. The nurse on duty had full responsibility for administering medicines. There was a sufficient supply of medicines and nurses who administered medicines had received training. Records demonstrated arrangements had been made for all trained staff to be assessed to ensure their competence to undertake this annually. The assessment was an observation of how staff safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care'. We observed that unused medicines were discarded safely and in accordance with the administration of medicines policy. Stocks of medicines showed people received them as the prescriber intended. When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

There were suitable systems to protect people by the prevention and control of infection. People told us the home was kept clean and hygienic. Records showed that the management team had assessed, reviewed and monitored what provision was needed to ensure that good standards of hygiene were maintained in the service. The service completed audits to support good practice in hand washing and controlling infectious diseases. We found that the accommodation was clean and had a fresh atmosphere. We noted that equipment such as hoists and commodes were in good condition, had washable surfaces and were clean.

We noted that soft furnishings, beds and bed linen had been kept in a hygienic condition. We observed that care staff recognised the importance of preventing cross infection. They had access to antibacterial soap and regularly washed their hands. The service had been awarded a four-star rating for food hygiene by the Foods Standards Agency. This is the second highest award that can be made and demonstrated food was prepared and stored hygienically.

We found that the registered manager had ensured that lessons were learned and improvements made when things had gone wrong. For example, checks on emergency lighting spotted that a battery was not working which the provider replaced and following an internal fire risk assessment staff identified that more signage was needed to guide people to fire exits which the provider responded to by adding more signage. Records showed that they had carefully analysed accidents and near misses so that they could establish how and why they had occurred. We noted that actions had then been taken to reduce the likelihood of the same thing happening again. These actions included considering the need to refer people to specialist healthcare professionals who focus on helping people to avoid falls.

Good

Is the service effective?

Our findings

People's clinical and support needs were assessed using recognised tools following the guidelines from the National Institute of Clinical Excellence. These included nutrition, skin integrity and dependency, people's care was designed following the guidelines from the assessment such as when people were at risk of losing weight, monitoring was put in place. We found that robust arrangements were in place to assess people's needs and choices so that personal care was provided to achieve effective outcomes. Records showed that the registered manager had carefully established what assistance each person needed before they moved into the service. This had been done to make sure that the service had the necessary facilities and resources to meet the person's needs. Records showed that the providers assessment had suitably considered any additional provision that might need to be made to ensure that people did not experience discrimination. An example of this was the registered manager clarifying with people if they had a preference about the gender of the care staff who provided them with close personal care.

If people displayed behaviours, which may challenge, these were monitored and, where required, people were referred to health professionals. Care plans provided guidance to staff so that they managed situations in a consistent and positive way, which protected people's dignity and ensured that human rights were protected. The care plans described the steps they should take when supporting people who may present with distressed reactions to other people and/or their environment. Staff were able to tell us about individual triggers, which might affect people's behaviour, and different techniques they used to defuse and calm situations. The staff told us they did not use direct restraint and used various supervision and communication techniques and their knowledge of the person to keep people safe. These plans were reviewed regularly and where people's behaviour changed in any significant way saw that referrals were made for professional assessment in a timely way. During our inspection, we observed sensitive interventions by staff that recognised triggers for behaviours.

For two people, the care plans indicated that staff were to document the behaviours on an Antecedent-Behaviour-Consequence (ABC) Chart. This direct observation tool can be used to collect information about the events that are occurring for a person within an environment. "A" refers to the antecedent, or the event that precedes behaviour. The "B" refers to observed behaviour, and "C" refers to the consequence. Records had been fully completed which meant people's behaviours had been reviewed and analysed to ensure the support from staff was the most appropriate.

People said they felt supported by staff who understood their needs. New staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they can carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Inductions included areas such as the geography of the home, communication systems, policies and procedures. Induction training was followed by a minimum of three shadow shifts.

Staff told us that they received support and supervision from the management team and could speak to

them at any time. The registered provider's records reflected what we had been told. We found records demonstrating other ways staff were supported. This was through staff monthly team meetings. Minutes of these discussions demonstrated staff discussed people's needs, activities, changing policies and procedures, safeguarding and training needs. It was clear staff possessed a high degree of knowledge about the people they were caring for. This was confirmed in our discussions with staff.

The provider maintained a spreadsheet record of training in courses completed by staff which the provider considered as mandatory to providing effective care. This allowed the provider to monitor when this training needed to be updated. These courses included fire safety, infection control, moving and handling, health and safety, food safety, safeguarding people, record keeping and the Mental Capacity Act (MCA). Additional training was available to staff in specific conditions such as nutrition, dementia training delivered by the Alzheimer's Society and challenging behaviour training. Staff had received on-going refresher training to keep their knowledge and skills up to date. Nurses had completed additional clinical training such as wound management to keep up to date with current guidelines. A psychologist within the local community team in West Sussex became involved with a person when they moved into the home due to their increase in challenging behaviours. In a review report about the person, the staff team were complimented on how well they had worked with the individual over a period of time, resulting in the behaviours reducing and the psychologist discharging the person. This was due to the skills, training and rapport the team had.

People were supported to eat and drink enough to maintain a balanced diet. The chef explained to us the importance of how food played a role in a person's day and in their health. They spoke passionately about being able to provide home cooked food. The kitchen staff were aware of people's dietary requirements including pureed and vegetarian diets. People had a choice of meals, if people did not want what was offered they could choose an alternative. We observed the lunchtime meal, staff supported people with their meals when required, giving people time to enjoy their meals. People were encouraged to eat independently using equipment such as specialist cutlery and plate guards.

People had been offered the opportunity to have their body weight regularly checked so that any significant changes could be brought to the attention of a healthcare professional. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The registered manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. For example, if a person needed to be taken to hospital by the ambulance service, people had 'Hospital Passports' that contained essential information, should this be needed quickly. They contained information about family contacts, medicines, details of medical history and do not attempt cardiopulmonary resuscitation (DNACPR) if this was in place. This ensured health professionals would have the required information to be able to support people in line with their needs and preferences.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dieticians. People's weight was monitored monthly, when people lost weight they were given a fortified diet with higher calories and fat content and referred to the dietician. Some people had difficulty swallowing, they had been referred to the speech and language therapist for

assessment. People were supported to attend hospital appointments and raise concerns they have about their health.

We found that people's individual needs were suitably met by the adaptation, design and decoration of the accommodation. The service was one adapted building, people's accommodation was over three floors, with a passenger lift. The bathrooms had been adapted so that people who used a wheelchair were able to access them. There was sufficient communal space in the dining room and in the lounges. Everyone had their own bedroom that was laid out as a bed sitting area so that people could spend time in private if they wished. People told us that they had been encouraged to bring in items of their own furniture and we saw examples of people personalising their bedrooms with ornaments, personal memorabilia and photographs.

People had access to the garden, which was flat and wheelchair accessible. Signage was displayed around the home to orientate people to communal spaces and toilets. Parts of the home with people's rooms were given street names and themed with matching coloured floors and hand rails to help with orientation for example Green lane, Lavender lane and Daffodil lane. Each floor had an orientation sign that had been updated with the date, the season and the weather outside. People with dementia told us they found this useful.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 authorizations to deprive a person of their liberty had the appropriate legal authority and were being met and we found they were.

People were supported to make decisions about their daily lives including how they spent their time and what they had to eat. People were encouraged to be involved in making complex decisions about their care and their decisions were respected. When people were unable to make a decision, best interest meetings were held involving people that knew the person well, and these were recorded. People had been assessed and DoLS applications had been made as appropriate. Some people had restrictions on their liberty authorised by the local DoLS team and their care plans included instructions on how to support them in line with these. For example, if a person was unable to leave the premises unaccompanied due to risk, this was authorised by the DoLS team to ensure people were being cared for lawfully. Any restrictions on people's activities under the Mental Health Act (MHA) 1983 were recorded in their support plans and staff were aware of the reasons for these and the support guidance. There was a system in place to ensure that when the DoLS authorisations were due to end, staff applied for them in a timely manner.

Good

Is the service caring?

Our findings

Staff were observed to be kind and sensitive to the needs of each individual at the home, staff knew people well and knew how to support them. Staff were quiet, patient and discreet with people. For example, one person became distressed if staff touched their clothes but the person responded well to one member of staff and staff knew that if the person needed to be encouraged to change their clothes which staff member would elicit the best response from the person to reduce and avoid any possible distress. Our observations showed us people were positive about the care and support they received. People smiled, laughed, nodded their heads and told us they liked the staff. Interactions we saw were comfortable, friendly, caring and thoughtful. Staff behaved in a professional way. People enjoyed the relaxed, friendly communication with staff. There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people, they explained what they were doing first and reassured people.

We observed a staff member holding a person's hand while they were chatting, the staff member was bending down so she was at eye level, not overbearing and patiently listening to what the person was trying to tell her. The staff member did not rush the person or prompt them to get their words but waited until they had finished speaking before she replied. When the staff member did so, she spoke softly to explain that the persons relative would be coming in to see them later that day and she would make sure that they did not miss them. The person was reassured and content with the response.

People and, where appropriate, their families were involved in discussions about developing their care plans, which were centred on the person as an individual. We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Records showed that the management team had encouraged their involvement by liaising with them on a regular basis. Care plans included people's preferences around clothes, when people wanted to get up or go to bed and their choice of how and where to eat and how to spend their day. Preferences were clear on whether people had chosen to have a bath or shower and how often. One visiting relative told us that they had been involved in their loved one's care plan. No one told us they had any concerns about their care plan or how often it was revised.

People were supported to maintain important relationships. Where people required help to maintain relationships, staff were at hand to help with correspondence such as birthday cards, emails, social media or letters. This helped to ensure that people could maintain close links with loved ones.

People were encouraged to be as independent as possible. Many people had previously lived in the local community and were encouraged to carry on routines such as visiting friends or local shops. Staff could provide support to facilitate these visits if required. Where people went out independently, they had agreements in place with staff about where they were going and time of expected return. This helped to ensure that staff had an awareness of people's whereabouts if they did not return as expected. One person had a communication plan which encouraged and suggested ways staff could increase the person's sense of independence and self-esteem. Staff were encouraged to talk to the person in places where there was not much background noise and to use active listening skills. The person had a care plan for delusions and

socialisation that had the goal of supporting the person to lead a fulfilling life, minimise social isolation; exclusion, misunderstanding and frustration. Staff were encouraged to enable the person to attain optimum contact with reality by increasing interactions and decrease feelings of isolation. Daily notes showed that staff had established which staff elicited the best response from the person and maximise the continuity of care.

The provider demonstrated a clear understanding through the planning and delivery of care about the requirements set out in The Equality Act (2010) to consider people's needs on the grounds of their protected characteristics. The Equality Act is the legal framework that protects people from discrimination on the grounds of nine protected characteristics including age, sex and disability. Staff had all received training in equality and diversity and there were policies in place to help ensure staff were considering people's individualised needs in the delivery of care. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected.

People's privacy, dignity and independence were respected and promoted. We noted that care staff recognised the importance of not intruding into people's private space. Bedroom, bathroom and toilet doors could be locked when the rooms were in use. People had their own bedroom that they had been encouraged to make into their own personal space. We saw care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms.

The provider was proactive in ensuring that they complied with Accessible Information Standards. These are standards introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. The service adapted to meet people's needs for example a person's care plan showed that staff were encouraged to check a person's hearing aids, support them to change their batteries and to keep their glasses clean.

We found that care records were stored securely. Policies and procedures we looked at showed the service placed importance on protecting people's confidential information. Staff handed over information to each other away from communal areas. This helped to ensure that personal or sensitive information about people was kept private.

Good

Is the service responsive?

Our findings

Care records showed people's needs were assessed prior to being admitted to the home. Care plans reflected individual needs and how people preferred to receive support from staff. The care records showed attention to detail regarding personal care such as oral health care and people's needs at night. Each person had information in their records detailing their preferred routines, preferences and life history. Staff told us, they found the care plans informative and provided them with enough detail to support people's individualised needs. Peoples care records included a personal profile, one detailed the persons likes and preferences such as liking classical music, golf and their favourite newspaper to read. The care plan supported the person maintaining their independence, for example, the person was independent with bathing but staff supported to get towels and toiletries ready and to check on the person while they were bathing at regular intervals to check they were safe as the person had been assessed as at risk of overfilling their bath.

Information about each person was detailed and written in a person-centred way focussing on their abilities and strengths. The care records contained detailed information to guide staff on the care and support to be provided. They showed that risks to people's health and well-being had been identified, such as the risk of poor nutrition and the risk of injury. Where a risk had been noted, action to reduce or eliminate any identified risk was recorded in detail. Charts were completed to record any staff intervention with a person, for example, recording food intake, an identified risk regarding mental health, and when 'as required' medication might be used.

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were recorded, so staff could support people to remember happy times or be supported at sad times. This enabled staff to see what was important to the person and how best to support them.

Staff told us they completed a handover sheet after each shift which outlined changes to people's needs. We looked at these sheets and saw that the information related to a change in people's medicine, healthcare appointments and messages to staff. Daily records were completed to record each person's daily activities, personal care given, what went well and what did not and any action taken.

People confirmed that they took part in the activities in the home and in the local community. The activities programme was broken down to regular daily activities, which changed according to needs. In addition, weekly activities and entertainment, were booked from external sources. People confirmed they liked the activities on offer.

Each week an activity meeting took place, we reviewed the minutes of these meetings. The meetings involved the management team and the activities coordinator. The meeting agenda discussed the Sunday film club and people's preferences for the coming week. Minutes showed discussions of pat dog visits and plans for Christmas. People had chosen and were being supported to take part in a local community competition where the proceeds would go to a local charity. Staff discussed how to make Christmas special

for people by having a special meal and giving gifts. People told us, they looked forward to this and was an event they were excited about celebrating together as a home.

'Resident Meetings' enabled people to express their needs and preferences in their care and towards the home and environment. 'Resident Meetings' were held every two months and involved people that wanted to give their feedback. We found an example of a person unable to attend one of these meetings due to having a visitor at the time. The minutes reflected, they were asked for their feedback later in the day, the minutes reflected the person stating 'everyone here is lovely and that everyone is well looked after. The food is excellent and I have no concerns.'

There were robust arrangements to ensure that people's concerns and complaints were listened and responded to, to improve the quality of care. Most people told us that they had not needed to make a complaint about the service. However, they were confident that if there was a problem it would be addressed quickly. People's concerns and complaints were encouraged, explored and responded to in good time. Formal complaints were dealt with by the management team, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy. People said that they would be confident to make a complaint or raise any concerns if they needed to.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. The home obtained guidance and best practice techniques from professional bodies to assist them in providing good quality end of life care. Records showed that the management team had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home.

Good

Is the service well-led?

Our findings

We found that the registered manager understood and managed risks and complied with regulatory requirements. Records showed that the registered manager had subscribed to professional websites to receive up to date information about legal requirements that related to the running of the service. This included CQC's website that is designed to give providers and registered manager's information about important developments in best practice. This is so they are better able to meet all the key questions we ask when assessing the quality of the care people receive. In addition, we noted that the registered manager had correctly told us about significant events that had occurred in the service. These included promptly notifying us about possible safeguarding incidences.

The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

Staff were clear about their responsibilities. The registered manager had experience of working in adult social care and displayed a sound knowledge of the service's policies and procedures and the individual needs and preferences of people who used the service. A deputy manager and administrator worked alongside the registered manager and co-ordinated and monitored people's care packages. They were also responsible for staff support, staff training and review of their practice.

People told us they felt the registered manager was approachable and the home was well managed. There was an open-door policy as we saw people, including their relatives, go into the office throughout our inspection. There was visible leadership and management support available to staff. The registered manager was available during the day to give support and direction to staff. An on-call duty system was in place to ensure staff had out of hours support when needed. Staff we spoke with were positive about the culture of the service and told us that they felt they could approach the management team if they had any problems and that their concerns would be listened to. A care staff member told us "It's a nice home, I like it, I'm enjoying it." A nurse told us "It's a nice establishment, all the staff are learning together, most staff have been here together from the beginning which is really good."

There were systems in place to make sure the service assessed and monitored its delivery of care. We saw there were various audits carried out such as medicines, health and safety, room maintenance and housekeeping. Accident records were kept which contained a description of the accident, time it occurred and if people required hospital treatment. The registered manager conducted an analysis to help identify trends and patterns for example the number of times people used the call bell and the reasons why. The registered manager was a registered nurse, conducted care quality audit's and for example, checked peoples weight monitoring records to ensure they were being appropriately cared for. The registered manager used this as an assurance exercise to look at staff knowledge and ensure that the dietary needs of people was up-to-date and people were making appropriate progress in maintaining and/or increasing to a healthy weight.

The registered manager promoted a caring, positive, transparent and inclusive culture within the service. They actively sought the feedback of people, relatives and staff. People's and relatives feedback was sought and used to improve people's care. Feedback came from regular meetings with people and their relatives and annual surveys for people and relatives. Comments were positive from a recent survey and any suggestions made were taken on board by the registered manager and acted on. Minutes for a 'Resident Meeting' showed that people were given opportunity to chair the meeting. One relative said, "It is a wonderful place and [person] has never known a place like this before." One person said, "We have made it a beautiful place with wonderful people."

The registered manager adopted a prudent approach to ensuring the sustainability of the service. This included operating efficient systems to manage vacancies in the service. We saw that the management team carefully anticipated when vacancies may occur and liaised with local commissioning bodies so that new people could quickly be offered the opportunity to receive care in the service. This helped to ensure that sufficient income was generated to support the continued operation of the service.

The service worked in partnership with other agencies. There were examples to confirm that the provider recognised the importance of ensuring that people received 'joined-up' care. We asked the registered manager where he went for clinical advice or for a professional conversation, he identified the community mental health team was his go-to source. This included those who commissioned the service, safeguarding and other professionals involved in people's care.