Beech House Care Homes Ltd

Chestnut House

Inspection report

69 Crumpsall Lane
Crumpsall
Manchester
Greater Manchester
M8 5SR

Tel: 01617214949

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09 May 2017
10 May 2017

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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

Chestnut House is a care home providing personal care and accommodation for up to 19 older people and is owned by Beech House Care Homes Limited. No nursing care is provided. The home is situated in the Crumpsall area of Manchester.

At the last inspection of October 2015 the service did not meet all the regulations we inspected and were given two requirement actions for governance and keeping care plans and risk assessments up to date. The service sent us an action plan to show us how they intended to meet the regulations. At this inspection we saw the improvements had been made and the regulations were met. This unannounced inspection took place on the 09 and 10 May 2017.

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

Staff we spoke with were aware of how to protect vulnerable people and had safeguarding policies and procedures to guide them, which included the contact details of the local authority to report to.

Recruitment procedures were robust and ensured new staff should be safe to work with vulnerable adults.

The administration of medicines was safe. Staff had been trained in the administration of medicines and had up to date policies and procedures to follow. Their competency was checked regularly.

The home was clean and tidy. The environment was maintained at a good level and homely in character. We saw there was a maintenance person to repair any faulty items of equipment.

There were systems in place to prevent the spread of infection. Staff were trained in infection control and provided with the necessary equipment and hand washing facilities. This helped to protect the health and welfare of staff and people who used the service.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation plan (PEEP) and there was a business plan for any unforeseen emergencies.

People were given choices in the food they ate and told us it was good. People were encouraged to eat and drink to ensure they were hydrated and well fed.

Most staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of her responsibilities of how to apply for any best interest decisions under the Mental Capacity Act (2005) and followed the correct procedures using independent

professionals.

New staff received induction training to provide them with the skills to care for people. Staff files and the training matrix showed staff had undertaken sufficient training to meet the needs of people and they were supervised regularly to check their competence. Supervision sessions also gave staff the opportunity to discuss their work and ask for any training they felt necessary.

We observed there were good interactions between staff and people who used the service. People told us staff were kind and caring.

We saw that the quality of care plans gave staff sufficient information to look after people accommodated at the care home and they were regularly reviewed. Plans of care contained people's personal preferences so they could be treated as individuals.

People were given information on how to complain with the details of other organisations if they wished to go outside of the service.

Staff and people who used the service all told us managers were approachable and supportive.

Meetings with staff gave them the opportunity to be involved in the running of the home and discuss their training needs.

The manager conducted sufficient audits to ensure the quality of the service provided was maintained or improved.

There were suitable activities to provide people with stimulation if they wished to join in.

The service asked people who used the service, family members and professionals for their views and responded to them to help improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service used the local authority safeguarding procedures to report any safeguarding to. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Arrangements were in place to ensure medicines were safely administered. Staff had been trained in medicines administration and managers audited the system and staff competence.

Staff were recruited robustly to ensure they were safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS and should recognise what a deprivation of liberty is or how they must protect people's rights.

People were given a nutritious diet and said the food provided at the service was good.

Induction, training and supervision gave staff the knowledge and support they needed to satisfactorily support the people who used the service.

Is the service caring?

Good

The service was caring.

People who used the service told us staff were helpful and kind.

We saw visitors were welcomed into the home and people could see their visitors in private if they wished.

We observed there were good interactions between staff and people who used the service.

Is the service responsive?

Good

The service was responsive.

There was a suitable complaints procedure for people to voice their concerns. The registered manager responded to any concerns or incidents in a timely manner and analysed them to try to improve the service.

People were able to join in activities suitable to their age, gender and ethnicity.

Plans of care were developed with people who used the service, were individualised and kept up to date.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the quality of care and service provision at this care home.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

Staff told us they felt supported and could approach managers when they wished.

Chestnut House

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.

One inspector conducted the inspection over two days. We arrived unannounced on the 09 May 2017 and we returned on the 10 May 2017 to complete the inspection.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. We asked the local authority contracts and safeguarding teams for their views about the service. They did not have any concerns.

We did not request 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 did look at other information we held about the service and used it to help plan the inspection.

During the inspection we talked with three people who used the service, the registered manager, the deputy manager, two care staff members, the activities coordinator, a district nurse and the area manager.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records for three people who used the service and medicines administration records for eight people. We also looked at the recruitment, training and supervision records for three members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

People who used the service told us, "That's one thing you can say. I feel very safe. Nobody bothers me", "I feel very safe. I was scared of someone but once I got to know the person it was OK. I feel safe now" and "I feel safe. I like it here."

From looking at staff files and the training matrix we saw that staff had been trained in safeguarding topics. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service had a copy of the local social services safeguarding policies and procedures. This meant staff had access to the local safeguarding team for advice and to report any incidents to. There was a whistle blowing policy and a copy of the 'No Secrets' document available for staff to follow good practice. A whistle blowing policy allows staff to report genuine concerns with no recriminations. The staff we spoke with were aware of abuse issues and said, "I am aware of the whistle blowing policy. I would be prepared to report poor practice", "I am aware of the whistle blowing policy and aware of issues surrounding safeguarding. I have used the whistle blowing policy. I was supported and the manager took action" and "I would not hesitate to report anything I saw was wrong." There had not been any safeguarding incidents since the last inspection. There were systems in place to help protect people from abuse.

On the first day of the inspection we saw the registered manager was on duty, a cook, three care assistants (one senior), a person who worked in the laundry, a domestic, an activities coordinator and a maintenance person who worked 24 hours each week. The area manager was present and supported the new manager on both days of the inspection. We saw from looking at the duty roster that the skill mix and numbers of staff were normal for this service. We heard staff answering the call bells promptly and staff sat talking to people when they had a free moment. People's needs were met by adequate numbers of skilled staff.

We looked at three staff files. We saw that there had been a robust recruitment procedure. Each file contained at least two written references, an application form with any gaps in employment explored, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a decision taken to employ the person or not. This meant staff were suitably checked and should be safe to work with vulnerable adults.

We saw that the electrical and gas installation and equipment had been serviced. There were certificates available to show that all necessary work had been undertaken, for example, gas safety, portable appliance testing (PAT), the lift, slings, hoists and the nurse call and fire alarm system. The maintenance person also checked windows had restricted openings to prevent falls and the hot water outlets were checked to ensure they were within safe temperature limits. There was a system for reporting any faults or breakages. The maintenance of the building and equipment helped protect the health and welfare of people who used the service and staff.

Fire drills and tests were held regularly to ensure the equipment was in good working order and staff knew

the procedures. Each person had a personal emergency evacuation plan (PEEP) which showed any special needs a person may have in the event of a fire. A copy of the PEEP was kept in each bedroom and by the front door to pass to the emergency services. There was a fire risk assessment and business continuity plan for unforeseen emergencies such as a power failure, loss of the gas supply and extreme weather.

We observed a member of staff administering medicines and saw they used safe procedures. We looked at the policies and procedures for the administration of medicines. The policies and procedures informed staff of all aspects of medicines administration including ordering, storage and disposal. All staff who supported people to take their medicines had been trained to do so and had their competency checked by the registered manager to ensure they continued to safely administer medicines.

We looked at eight medicines administration records (MARs) and found they had been completed accurately. There were no unexplained gaps or omissions. Two staff members had signed they had checked medicines into the home. This helped staff check the numbers of medicines people had.

There was a controlled drug cupboard and register. Controlled drugs are stronger and require more stringent administration. We saw that two staff had signed the controlled drugs register. One member of staff signed when they administered the medicine and the second was a witness to it. The MAR sheet was also signed. This was in line with current guidance. We checked the medicines in the cupboard against the number recorded in the register and found they were accurate.

Medicines were stored in a trolley in a locked room. The trolley was chained to a wall. This ensured only people qualified to administer the drugs had access to them. Dressings were stored in separate cupboards. The temperature of the medicines room was checked daily as was the medicines fridge to ensure medicines were stored to manufacturer's guidelines.

The medicines system was audited by staff daily and managers completed a full weekly audit and spot checks. This helped spot any errors or mistakes. Staff retained patient information leaflets for medicines and also a copy of the British National Formulary to check for information such as side effects.

There were clear instructions for 'when required' medicines. The instructions gave staff details which included the name and strength of the medicine, the dose to be given, the maximum dose in a 24 hour period, the route it should be given and what it was for. This helped prevent errors.

Any medicines that had a used by date had been signed and dated by the carer who had first used it to ensure staff were aware if it was going out of date.

There was a signature list of all staff who gave medicines for management to help audit any errors. The service had a copy of the NICE guidelines for administering medicines. This is considered to be best practice guidance for the administration of medicines.

We saw that topical medicines such as ointments were recorded in the plans of care. The service used body maps to show staff where to apply the medicines.

We looked in the trolley and saw it was a bio-dose system. The trolley was clean and tidy and not overstocked. There were sufficient supplies of medicines. Any medicines that were not used and needed to be returned to the pharmacy were recorded and stored in a locked cupboard. However, the box used was not tamper proof and could be open to abuse. A tamper proof box was arranged during the inspection.

We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service.

We looked at three plans of care during the inspection. We saw people had risk assessments for falls, the prevention of pressure sores, mental capacity, nutrition and moving and handling. Where a risk was identified the relevant professional would be contacted for advice and support, for example a dietician. We saw the risk assessments were to help keep people safe and did not restrict their lifestyles.

There was also environmental risk assessment to ensure all parts of the service were safe. This covered topics like tripping hazards, faulty or broken equipment and the outdoor space.

During the tour of the building we noted everywhere was clean, tidy, well decorated and there were no malodours. There were policies and procedures for the control and prevention of infection. There was a notice board dedicated to infection control with information for staff to follow such as hand washing advice. A member of staff was a nominated lead for infection control.

The training matrix showed us most staff had undertaken training in the control and prevention of infection. Staff we spoke with confirmed they had undertaken infection control training. The service used the Department of Health's guidelines for the control of infection in care homes to follow safe practice. The registered manager conducted infection control audits and checked the home was clean and tidy.

There was a laundry sited away from any food preparation areas. There was one industrial type washing machine and dryer to keep linen clean and other equipment such as irons to keep laundry presentable. The washing machines had a sluicing facility to wash soiled clothes. There were different coloured bags to remove contaminated waste and linen. There was a system of dirty clothes in and clean clothes out of the laundry to prevent cross contamination. There were hand washing facilities in strategic areas for staff to use in order to prevent the spread of infection, including the laundry. Staff had access to personal protective equipment such as gloves and aprons. We observed staff used the equipment when they needed to.

Good

Is the service effective?

Our findings

People who used the service told us, "The food is very good. You get a very good choice", "The food is good. It has to be mashed for me but it still has all the flavour" and "The food is excellent. There is a lot of choice."

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We were present in the dining room for part of the inspection to observe a mealtime and saw that staff were attentive and talked to people who used the service. Tables were attractively set and people had a choice of condiments to flavour their food. The dining room contained sufficient seating for all although some people remained in their rooms if this was their choice or were on bed rest.

The cook said she talked to staff and people who used the service to see what they liked and did not like and adjusted the menu accordingly. We saw the cook check on how the meals had gone on both days of the inspection. The cook also told us she had a list of people's dietary needs and allergen advice for any foods not freshly made. There was nutritional advice on a notice board with information on how to safely feed people and advice on herbs and their uses.

There was a choice at each meal and other foods available at any mealtime. People could choose from any of the usual breakfast foods such as cereals, a fully cooked breakfast or eggs on toast. There was a choice of a lighter lunch and a choice of the main meal in the evening. A dessert was offered with lunch and tea. Hot or cold drinks were served with meals, at set times during the day and upon request. People had fruit juice in their rooms to drink when they wanted.

We saw the main meal at a tea time was either chicken lattice pie or grilled gammon, potatoes and vegetables. We looked at the menus and saw there was a selection of well balanced meals.

The kitchen had achieved the five star very good rating from the last environmental health inspection which meant food ordering, storage, preparation and serving were safe. We went into the kitchen and found it to be clean and tidy. We saw there was a cleaning rota and a good supply of fresh, frozen, dried and canned foods. This included fresh fruit which was made available daily.

The service provided special diets for any person who required one. This included Halal meals, vegetarian dishes and pureed or mashed foods. The cook told us that family members of people with cultural or ethnic needs provided advice but also liked to bring in meals for their family members as part of the visiting process.

People's food choices were recorded in the plans of care as were any special diets or pureed food. For people who were at risk of malnutrition we saw that fortified drinks were offered and full fat milk and cream used to provide more calories.

Each person had a nutritional assessment and we saw that where necessary people had access to

specialists such as dieticians or speech and language therapists (SALT). People's weights were recorded regularly to ensure they were not gaining or losing weight.

People who used the service told us, "I have a nice room. They keep it very clean", "I have a nice room. It is just being decorated. I helped choose my own decoration" and "They keep my room very clean and the home is very clean. I have a lovely room."

We toured the building during the inspection and visited all communal areas, six bedrooms and the bathrooms. The home was clean, tidy and fresh smelling. Bedrooms we visited had been personalised to people's tastes. We saw people had family photographs, personal furniture, televisions, radios and ornaments to help the room feel more homely. People told us they had chosen the décor for their bedrooms and we saw that many rooms were individual to their tastes.

We saw that since the last inspection signage had been improved to help people with a dementia locate their way around the building. Bathrooms and toilets were clearly signposted. There was a photograph of each person on their bedrooms doors.

There had also been improvements to the environment with two bathrooms being refurbished and rooms decorated including the quiet lounge. Both baths had a lifting device for people who had mobility problems. People had access to a variety of communal areas including an activities room and hairdressing salon.

The communal areas were well decorated and had sufficient seating for people accommodated at the home. The communal areas were homely in character and a television was available for people to watch if they wished.

There was a lift to access both floors. There was an accessible garden which was being tidied up during the inspection for people to use in good weather. The garden contained lots of plant pots which we were told were part maintained by people who used the service.

A member of staff said, "Part of my role is to help new staff go through the induction." We saw from looking at staff files that new staff received an induction and had completed the relevant paperwork. New staff were taught the rules for working at the home, for example attending staff handovers, were given a copy of the staff handbook, had to read key policies and procedures and aspects of care such as moving and handling. Staff were shadowed until they felt confident to work upon their own and management were satisfied they were competent. New staff were then enrolled on the care certificate which is considered best practice for staff new to the care industry.

A person who used the service said, "I think the staff are very well trained. They all work well together." Two staff members said, "I think we do enough training to feel competent to do the job" and "I have completed all the mandatory training. I am now training for medicines administration, Autistic disorders and learning disability. I have also completed training for the care of people with dementia, end of life care and nutrition."

We saw from looking at the training matrix, staff files and talking to staff that training was ongoing. Training included the MCA, DoLS, first aid, food safety, medicines administration, moving and handling, infection control, health and safety, safeguarding and fire awareness. Some staff had received further training in the care of people with dementia, the six steps end of life care, nutrition and behaviours that may challenge. Staff were encouraged to take a recognised course (NVQ or Diploma) in health and social care. We saw that refresher and further training was planned for future dates. Staff were sufficiently well trained to perform their roles.

Staff told us, "I have had competency check for medicines, supervision and appraisal. You can discuss what you want including your career", "I have supervision with the manager. You can bring up training or other issues. You can also bring up topics at staff meetings" and "I have had my supervision and appraisal. There are also staff meetings. We all sit round a table and have a chat. You can have your say at meetings or supervision." We saw from looking at the supervision matrix that staff received regular supervision and this enabled them to discuss their training needs and performance.

From looking at three plans of care we saw that people who used the service had access to professionals, for example psychiatrists and other hospital consultants, community nurse specialists and district nurses. Each person had their own GP. This meant people's treatment was regularly followed up and any new treatment could be commenced.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). 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. Most members of staff had been trained in the Mental Capacity Act 2005 (MCA 2005).

We saw from three plans of care that people had a mental capacity assessment which was reviewed regularly. Where people lacked mental capacity a best interest meeting was held. The registered manager said the mental capacity assessment was undertaken before people were admitted to the home to ensure they could meet their needs. Best interest meetings included professionals and family members if appropriate to determine if the home was the right place for the person to remain. People had access to advocates or Independent Mental Capacity Advisors (IMCA). These professionals act independently to protect people's rights. There were 14 people accommodated at the home who had a DoLS in place and one more was awaiting a local authority decision. We saw there was information about independent mental capacity advisors and advocates available in the hallway.

Where possible people signed their agreement to care and treatment. This agreement covered sharing information when necessary, physical assessment, consulting with other professionals, photographs being taken, staff having access to his assessment and records and staff handling his personal allowance. Two of the three care plans we looked at people had signed their agreement and one person had an advocate to act upon their behalf. This meant people's rights were protected.

Good

Is the service caring?

Our findings

People who used the service said, "It is very good here. Very nice. The staff are great, very good, - and attentive. I am happy here. It is very good", "The staff are all very kind. Exceptional staff.
They look after me, very much so. I am happy here." and "The girls are perfect, they could not be any better. There are girls and boys here (staff) and they are all very kind." The people we spoke with were happy with the service and care they received.

A district nurse said, "I am new to the home but we have never had any problems here. Staff are accommodating. They know the service users well. They assist me very well. One person I see is quite anxious and they help to keep the person calm. The staff are welcoming and the atmosphere is very nice. I have no problems with this care home."

Staff said, "I like it here because it is small and we can all chat. I would be happy for a family member to live here" and "I think people are well looked after. I love coming to work. I like the atmosphere and the love staff have for the residents. It is a nice place to work. We can also have some fun and a laugh with the residents. If a relative needed this type of care I would not mind them living here. People and their relatives like it here because they say it is homely."

We observed staff during the inspection and how they interacted with people who used the service. Staff were professional, polite and had a good rapport with them. We did not see any breaches of privacy or witness anyone being treated in an undignified manner. We saw there was a good rapport between staff and people who used the service.

Staff were trained in confidentiality and data protection issues and had access to policies and procedures to help inform them of confidentiality issues. We saw that care records were stored safely and only available to staff who needed to access them. This ensured that people's personal information was stored confidentially.

Plans of care were personalised to each person and recorded their likes and dislikes, choices, preferred routines, activities and hobbies. This was in a document in the care plan called 'My life so far'. There was also information about what a person was capable of doing which helped them remain independent. There was a record of a person's spiritual or religious needs and we were told people who wished could attend a minister who came to the home if they wished to practice in this way. Family members of people from a different cultural or ethnic minority supported them to attend to their spiritual or religious needs.

We also saw that people were given the option of the gender of the care staff they wished to look after them. This was especially important for people from diverse backgrounds who wanted to be cared for by female staff.

We saw that visiting was open and unrestricted. We observed that any visitors were welcomed into the home and we were told people could have their visits in private if they wished. People were encouraged to maintain relationships with their family and friends.

Several staff had attended the six steps end of life care at a local hospice and we saw a certificate confirming this. This is a recognised course to assist staff to support people who used the service and their families at the end of their life. The staff who attended the course cascaded their knowledge down to the other staff who worked at the home.

We saw from looking at three plans of care that people had an end of life plan. This included details such as if a person had made a will and where it was kept, who the person wanted to be involved or informed, if they wanted burial or cremation, where they would like any ceremony to take place and if they had a preference for any particular undertaker. The plans were signed by the person. The ensured people's last wishes could be respected at the end of their life.

We saw there were many thank you cards on a notice board. Comments taken from a sample included, 'Thank you so much for looking after our relative. You all went above and beyond. You are all so caring which was genuine', 'Thank you for looking after me for the last few months; You made me feel very comfortable and safe', 'Thank you for all the loving care you gave to our relative and the kindness shown to us all' and 'Best wishes to you. You were fantastic'.

Good

Is the service responsive?

Our findings

People who used the service told us, "I get out every now and again with my family. The priest comes to see me. My religion is respected", "I like a drink in the evening. They don't mind. Cider or lager. I enjoy that" and "I like to read the newspaper and going to Morrison's supermarket." One person also told us they went out regularly with a friend for a drink to a local pub.

We spoke with the activities coordinator who said, "I take people to local to parks and we do lots of games around activities. Other activities include singalongs, jigsaws, various board games, going to the pub, one to one chats, cards, dominoes and gardening. We have a room for arts and crafts. We have a little greenhouse which we use to grow plants. At residents meetings people asked to help garden so we got started a group. We are growing lots of plants in pots in the garden. We ask each person what they would like to do at residents meetings. We also have themed days and do activities like making poppies or Easter bonnets. Outside entertainers come in as well and we help people get dressed up. People are also able to attend a religious service and we have had different denominations come here. Staff help with the activities and another member of staff does it when I am not here."

The activities coordinator had a file which showed people had joined in the activities. We saw records of arts and crafts and parties. People had a choice to join in the activities and the record detailed who attended the activity or why a person had not. Not all the people at the home liked to join in the activities. People were able to attend activities if they wanted to. This helped to keep people occupied.

People who used the service said, "I would talk to the manager if I had any concerns but I don't have any and I am happy with everything about the home" and "I have no complaints."

There was a suitable complaints procedure located in the hallway. Each person also had a copy in the documentation provided on admission. The registered manager had produced a simplified version for people who had a dementia. The complaints procedure told people how to complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of the Care Quality Commission. There had not been any complaints since the last inspection. However there was an auditing system which showed us how any complaints would be investigated and there was evidence from meetings and incidents that the registered manager responded in a suitable manner.

All the staff we spoke with said they had handovers at the beginning of every shift. The activities coordinator came on duty later and said she was kept informed of any changes. Staff were kept up to date with any changes or appointments people who used the service may have at staff handovers.

We looked at three plans of care during the inspection. Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Information was also obtained from other health and social care professionals such as the person's social worker. Social services

or the health authority also provided their own assessments to ensure the person was suitably placed. We saw that the assessments had been fully completed for each person. This process helped to ensure that people's individual needs could be met at the home.

All the people we spoke with thought they were well looked after. The plans of care showed what level of support people needed and how staff should support them. Each heading, for example personal care, tissue viability, mental health, diet and nutrition, mobility or communication showed what need a person had and how staff needed to support them to reach the desired outcome. The plans were reviewed regularly to keep staff up to date with people's needs. The quality of care plans was regularly audited by management. There was a daily record of what people had done or how they had been to keep staff up to date with information.

People were able to attend meetings regularly. Topics included items like food, the environment and if people were happy with their support. Each person was asked their opinion and we saw that the registered manager responded by producing an action plan. For example, one person remained in her room because that is what she wanted to do and people chose their own colour scheme in their bedroom after bringing it up at a meeting. Activities were due to be discussed at the next meeting.

Good

Is the service well-led?

Our findings

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

The registered manager was supported by the area manager during both days of the inspection.

We asked people who used the service and staff if they thought the home was well run and if they knew the managers. People told us, "You can talk to the manager. They are all approachable. It is a good place" and "The home is very nice. I cannot find anything wrong with management."

Staff said, "There is a good staff team. The managers are approachable. You can go to them if you need assistance", "The manager is supportive. He does not have to be in work and you can contact him. We all work well together and support each other. We have a good staff team" and "I love it here. It is a lot better since the new manager came. The manager is a good leader, very approachable and will help out. Any worries and it gets sorted out." Staff and people we spoke with were complimentary about the registered manager.

Staff were invited to attend regular meetings. At the last meeting of 06/04/2017 items on the agenda included staff breaks, staff finishing their shift early, toileting and pressure relief, completing paperwork correctly, rotas, training and the use of PPE. Staff were then asked if anyone wished to discuss anything. Staff discussed toiletries, laundry bags and the kitchen. From the meeting an action plan was completed which told us the item to be addressed, the required action, timescale for implementation, who was responsible and when the action had been completed. All staff signed a record sheet to show they attended the meeting. The registered manager told us any staff who were not able to attend the meeting would be updated during the handover. We saw that there were also meetings between senior staff, which were usually held prior to the general meeting to obtain their views.

We saw there was a service user guide and statement of purpose. Each person had a copy in their bedrooms to refer to. These documents gave people who used the service and professionals the details of the services and facilities provided at this care home.

During our inspection our checks confirmed the provider was meeting our requirements to display their most recent CQC rating. A copy of the latest inspection report was also made available for people to read.

We looked at some of the policies and procedures which included confidentiality, safeguarding, whistle blowing, medicines administration, health and safety, recruitment and selection, supervision and appraisals, complaints, privacy and dignity, equality and diversity, mental capacity, DoLS and infection control. Staff had to sign the policies to show they had read them. Policies and procedures were updated regularly and available for staff to follow good practice.

The area manager visited the home to conduct regular audits of the service. We were told some of the visits were unannounced. The area manager looked at what was outstanding from the last audit, interviewed residents, visitors if possible and a staff member. The audit also included the environment, including infection prevention and control, cleanliness, records, training, staff files and a sample of the paperwork.

The service also produced a report to the directors of the company. At the last one for May 2017 we saw the service provided information for CQC notifications, police or paramedic calls, pressure sores, people's weights, safeguarding alerts, accidents, behaviour charts, staff vacancies and any outside agency inspections. This was used to look for any ways the service could be improved.

The registered manager also conducted many audits. These included plans of care, the environment, infection control, notifications, incidents, accidents, medicines, health and safety, record keeping and cleanliness. Part of the process was to undertake random spot checks. We saw the registered manager then produced an action plan for any areas that needed improvement. We saw that improvements had been made, for example people who used the service were given assistive technology to reduce falls and a risk assessment was completed for a person who was refusing safe treatment.

The service sent out quality assurance questionnaires yearly. In 2016 the service sent survey forms to residents/family members and professionals. From looking at the surveys we saw the service had responded to some of the views and had improved the meals, provided a clearer menu and updated the décor. Relatives had been invited to come into the home to discuss how best they could improve. This showed the service responded to what people who used the service/relatives told them and acted upon it. Comments made on the returned forms included, "Our relative is comfortable, safe, secure and well cared for", "Overall I have found that the care of my relative has been excellent. The care team consists of well-motivated and professional individuals who relate well to the residents" and "I feel this home offers just what my relative wants. Her foibles are catered for in a professional and caring way."