Countrywide Care Homes (2) Limited

Astor Lodge

Inspection report

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Date of inspection visit: 23, 24 and 29 September 2015
Date of publication: 23/12/2015

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

Overall summary

Astor Lodge provides nursing and personal care for up to 29 people. At the time of the inspection 20 people were accommodated at the service, some of whom were living with dementia.

This unannounced inspection took place on 23, 24 and 29 September 2015. At the last inspection of this service, in September 2013, we found the provider was meeting all of the regulations we inspected.

The provider, Countrywide Care Homes (2) Limited, had two services on one site, Astor Lodge and Astor Court. We inspected both services at the same time. Our findings for Astor Court are discussed in a separate report.

A registered manager was in place. 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.

People told us they felt safe in the home. Staff had received safeguarding training and were able to describe the signs where people may be at risk of abuse and how they would respond if they had any concerns.

Summary of findings

Accidents and incidents were recorded and monitored and risks had been assessed. Actions had been identified to reduce the likelihood of risks occurring. Medicines were managed appropriately.

There were enough staff to meet people's needs. Staffing numbers had been determined following an assessment of people's needs. Staff were able to respond to people quickly. Safe recruitment procedures had been followed to ensure staff were suitable to work with vulnerable people.

Staff training was up to date. Staff were given opportunities to develop their skills and understanding. An induction training package was in place to ensure new staff were competent to deliver care to people safely.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Staff we spoke with, including the registered manager had a good understanding of the MCA. DoLS had been applied for and approval granted.

All of the people we talked with, and their relatives spoke highly of the staff. People described staff as kind, patient and caring. Relatives told us they always felt welcome. We observed good staff practice. Staff engaged people in conversation and responded to them warmly.

End of life care, and those people who wished to, had considered and planned for how they would like to be cared for as they approached the end of their lives.

People's needs assessments and care plans were detailed, specific and individual to the person receiving care.

People and relatives' feedback was encouraged through regular meetings and a yearly survey. The most recent satisfaction results had been very positive. Where people had raised areas for improvements, such as with the laundry service, action had been taken to improve the service. Complaints had been investigated and responded to.

People, relatives and staff spoke highly of the registered manager and told us the home was managed well.

A range of audits and monitoring tools were used to assess the quality of the service provided. Representatives from the provider organisation regularly visited the home and provided detailed feedback on their observations. Actions identified to improve the service had been carried out and signed off when completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People told us they felt safe at the home. Staff had undertaken safeguarding training and were able to describe to us how they would respond to any concerns.

There were enough staff to meet people's needs. Safe recruitment procedures had been followed to ensure staff had suitable qualifications and experience to carry out their role.

Medicines were managed appropriately. The home was clean and infection control policies were followed.

Good

Is the service effective?
The service was effective.

Staff training was up to date. Where people did not have capacity to make specific decisions, the principles of the Mental Capacity Act 2005 had been followed. Deprivation of Liberty Safeguard applications had been applied for appropriately.

The home was purpose built. There were a number of communal areas where people could choose to spend their time.

Good

Is the service caring?
The service was caring.

People told us staff were warm, friendly and compassionate.

Information had been provided for people about what they should expect from the service. Information was also displayed around the home about the needs of people with dementia, so people and relatives could read about best practice and research on dementia care.

Good

Is the service responsive?
The service was responsive.

Care records were personalised and contained clear information about how staff should support people. Assessments had been carried out to determine people's needs and were regularly reviewed.

People spoke very highly about the range of activities on offer in the home. We observed some of sessions organised by the activities coordinator, which people seemed to engage with and enjoy.

People and relatives' feedback was encouraged through regular meetings and an annual survey.

Good

Is the service well-led?
The service was well-led.

People spoke highly of the registered manager.

Audits and checks were carried out to monitor the quality of the service.

Good

Summary of findings

Representatives from the provider's organisation visited the home regularly to assess the quality of the service provided. Where improvements were identified, actions had been put in place to address them.

Astor Lodge

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 unannounced inspection took place on 23, 24 and 29 September 2015. The provider had two services on one site, Astor Lodge and Astor Court. We inspected both services at the same time. Our findings for Astor Court are discussed in a separate report.

The inspection was carried out by an inspector, a specialist advisor and an expert-by-experience. Specialist advisors are clinicians and professionals who assist us with inspections. The specialist advisor on this inspection was a registered nurse with a background in mental health nursing. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who was part of this inspection team had expertise in older people and those who had a dementia related condition.

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 the PIR and other information we held about the service prior to our inspection. This included reviewing statutory notifications the provider had sent us. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We reviewed information we had received from third parties. We contacted the local authority commissioning and safeguarding teams. We also contacted the local Healthwatch. We spoke with the pharmacist who supplied medicines to the home, and one person's care manager. We used the information that they provided us with to inform the planning of this inspection.

During the inspection we spoke with nine people who lived at the home and 14 relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Throughout the inspection we also spent time in the communal areas of the home observing how staff interacted with people and supported them.

We spoke with the registered manager, the provider's regional and quality assurance managers, a registered nurse, a senior care worker, three care workers and two domestic assistants. We reviewed four people's care records including their medicines administration records. We looked at personnel files for three care workers and three registered nurses, in addition to a range of records in relation to the management of the service.

Good

Is the service safe?

Our findings

We spoke with nine people who used the service who told us the home was a safe place to live. One person said, "Oh yes, I'm very safe here. The staff look after me." Another person said, "The staff are lovely and my room is kept clean."

Staff had undertaken training in identifying and responding to safeguarding concerns. Staff were able to describe different types of abuse, and how they would respond if they had any concerns that people were at risk of abuse. All of the staff we spoke with told us they would report concerns to their manager. The registered manager was aware of their responsibility to share any concerns with the local authority. There had been no concerns of a safeguarding nature within the previous 12 months, but historic records showed concerns had been reported promptly to the relevant safeguarding team.

People were protected from unnecessary risk. People's individual needs, the care they received and the premises had been assessed to determine any risks, people, staff or visitors may be subject to. Risk assessments were carried out based on people's needs. For example where one person required support to eat and had been referred to the speech and language team (SALT), risk assessments had been completed to determine their risk of developing malnutrition or choking. Information had been provided to staff about how to minimise these risks, such as by ensuring they received a liquidised diet. Where people were nursed in bed, risk assessments were in place to reduce the risk of developing pressure damage or falling out of their bed.

Accidents and incidents were monitored and analysed to determine if action could be taken to reduce the likelihood of them reoccurring. Accident and incident records included detailed information, for example, body maps where people had sustained an injury. The manager had reviewed all of the accidents records to ensure staff had responded appropriately. Accident and incident information was collated and reviewed on a monthly basis. Analysis included the times of accidents, whether they had been observed, and where in the home they had occurred. Action had been taken to reduce the risk of accidents reoccurring, for example we saw a referral had been made to one person's GP when they had fallen multiple times within a short period of time.

Checks were undertaken to ensure the building and equipment used was safe. External companies had been used to assess the electrical installations in the home, and the risk of asbestos or legionella bacteria forming or being present. Equipment such as the boilers and hoists had been serviced regularly to ensure they were in good working order. Maintenance staff regularly tested the call bell system to make sure people could contact staff if they needed them. Fire alarms and fire doors were tested on a weekly basis, and evacuation procedures were displayed throughout the home so staff were aware of the process to follow in the event of an emergency.

There were enough staff to meet people's needs. People we spoke with told us staff responded promptly to their requests. One person said, "I like all the carers, they talk to me and come quickly when I use my call bell." We observed lunch within the dining room on two days and saw there were enough staff to serve people quickly and help people who needed support to eat.

The majority of relatives we spoke with said the home was well staffed, however two relatives told us they thought more staff were needed. These relatives told us the main lounge was sometimes left without staff for up to 25 minutes. We spent time in the lounge during our inspection and saw the longest it was left without staff was ten minutes. We discussed this feedback with the manager who told us that staffing numbers were determined by an assessment of people's needs. We viewed the dependency assessment for the home, in addition to staff rotas from four weeks before our visit and confirmed staff numbers were consistent with the dependency assessments. Staff told us they had enough time to carry out their role. One staff member compared the home to a previous one they had worked in. They said, "It is so lovely here, to have time to spend with the residents and not be frantic trying to carry out care properly."

Safe recruitment practices had been followed, and a number of checks undertaken before staff began working in the service. Staff had provided proof of identification, information on their previous employment, and detailed any gaps in their employment history. Nursing staff files showed their registration had been checked with the Nursing and Midwifery Council (NMC) to ensure their registration was up to date and that nurses were fit to practice. References had been received from two referees,

Good

Is the service safe?

at least one of which was a previous employer. A Disclosure and Barring Service (DBS) check was in place for all staff. These checks were undertaken to ensure staff were of good character and suitably experienced to carry out their roles.

The home was clean. Domestic staff were responsible for cleaning communal areas, bedrooms, and for laundering people's clothes. Two relatives we spoke with told us they had previously made a complaint regarding the cleanliness of the home and the standard of housekeeping. They told us their relative's quilt cover was often left unbuttoned, that soft furnishings such as the valance on their bed or the tiebacks for their curtains were misplaced or put on the wrong way, and that the en-suite had been left dirty by staff. They described housekeeping standards as 'sloppy'. Following their feedback we checked five of the occupied 20 rooms. We found all of the rooms, including people's en-suites to be clean. We did note that some quilt covers had been left unbuttoned. We discussed what we had found and the relative's feedback with the manager. She told us that following their complaint she had sourced new 'envelope style' quilt covers without buttons to enable domestic staff to put them on quickly whilst staying securely attached to the quilt when it was in use. She also told us that she had recently decided to appoint a housekeeper whose role would include carrying out audits of domestic staff duties, and ensuring high standards in housekeeping were achieved.

Processes were in place to ensure medicines were managed safely. Nursing staff administered medicines to people assessed as having nursing care needs, and senior care workers administered medicines to people who were supported with their personal care only. All staff with responsibility to administer medicines had undertaken training in how to do so safely. Their competency had been assessed at least once a year, consisting of knowledge checks and observations of medicines administration. Medicines were stored securely. Records had been fully completed and codes had been used appropriately to record whether people had taken their prescribed medicines. We checked a number of medicines and saw medicines stock tallied with records. Topical medicines, such as creams, had been dated on opening, and a body map clearly showed where it should be applied. Processes were in place to dispose of any medicines which had not been used.

Good

Is the service effective?

Our findings

People we spoke with told us staff met their needs effectively. One person said, "The staff are good. They certainly know their stuff." Another said, "I couldn't be happier. The staff are marvellous." A relative told us, "The staff are skilled for what they do and handle [My relative] well."

The provider had identified a set of mandatory training requirements for care staff. These included a range of E-learning, classroom and practical training modules, in areas such as moving and handling, health and safety and safeguarding people from abuse. Training records showed staff training was all up to date. Training had been provided to staff, based around the needs of people who lived at the home, in areas such as dementia and end of life care.

New staff received a training induction package, which included training and shadowing more experienced staff. Staff worked towards completing the range of training required for the new Care Certificate [A framework for induction which outlines what care workers should know and be able to deliver in their daily jobs] in the first twelve weeks of their employment. They received regular supervision sessions and observations before their induction period was complete.

Staff were supported to develop their skills and knowledge. All of the staff we spoke with told us they thought they received enough training to prepare them for their role. Staff told us they discussed their training needs and their performance within supervision sessions with senior staff. Supervisions records showed these meetings were planned regularly, with set agenda items which encouraged staff to reflect upon their practice and the care they provided. Appraisals were held yearly, and included discussions on staff development and performance. Over 80% of care staff had been awarded, or were working towards Level 2 or 3 diplomas in Health and Social Care or equivalent. The nurse we spoke with told us they had access to training to maintain their registration. Registered nurses need to undertake 35 hours of learning activity within a three year period in order to meet the requirements to renew their registration.

People's healthcare needs were met by a range of health professionals. People told us staff contacted their GP quickly if they were unwell. During our inspection a GP visited one person at the staff's request. Care records showed people regularly had appointments with opticians, chiropodists, and dentists. Referrals had been made, based on people's needs, to district nurses, dietitians and speech and language therapists. Records showed recent contact had been made with the district nursing team for advice on pressure care and mattress types and a dietitian had been involved in assessing one person and arranging nutritional supplements for them.

We spoke with the registered manager and staff about the Mental Capacity Act 2005 (MCA). The MCA protects and supports people who may not be able to make decisions for themselves. Where people lack the mental capacity to make their own decisions related to specific areas of care, the MCA legislation protects people to ensure that decision making about these areas is made in people's 'best interests' in the form of best interest discussions. We saw a decision had been made to give one person their medicines covertly. This person frequently refused their medicines, which could have had a major impact on their health. We saw a GP, pharmacist and the person's family had been involved in the decision to give medicines within the person's food without telling them. A detailed care plan and risk assessment was in place so staff had information about how to administer the medicines safely. Clear records showed the assessment of the person's capacity to make the specific decision relating to their medicines. A multidisciplinary team, including staff from the home, a GP, a pharmacist and the person's relatives had been involved in making the decision, and records showed the considerations taken into account to ensure it was in the person's 'best interests'.

Where people had appointed Lasting Power of Attorney (LPA), to make decisions on their behalf, copies of these legal documents had been kept within people's care records. The manager was aware of the type of LPA [Health and Welfare or Property and Financial affairs] each person had in place, and the decisions their LPA could make on their behalf.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The provider acted in accordance with DoLS. At the time of our inspection the manager had applied for

Good

Is the service effective?

DoLS authorisation for 13 people. Where people had DoLS authorisation in place, care plans described to staff how they should support people if they tried to leave the home, such as using distraction techniques. Where people were not subject to DoLS they were able to leave the home whenever they chose to.

People told us they were happy with the food on offer in the home. One person said, “The food is really good.” People were asked their choice of meal in advance. People we spoke with told us they were happy to order their lunch meal on a morning when they were asked for their choice from the menu. However, for people living with dementia, being asked in advance could make their choice less meaningful, as they were unable to see or smell the food in front of them. The manager told us people’s choices would always be confirmed at the time of the meal, and alternatives provided if people changed their mind.

People’s nutritional needs were taken into consideration. Where people required a fortified diet, their meals were enriched with high calorie foods such as cream and butter. Food was prepared in line with people’s swallowing needs, and choices were available for people who required a soft diet. Where people were nursed in bed, condiments were taken to their room so they could flavour the meal to their liking. We saw one person, who was nursed in bed was supported to eat by a member of staff. The staff member engaged the person in conversation, they made comments such as “It’s quite nice and sunny today “, and asked; “Is this ok for you?” “Would you like anymore?”

The home was a purpose-built care home. Considerations had been made to enable people living with dementia to move around the home independently. For example, the handrails were a contrasting colour to the wall so people could see them easier. Corridors were wide and chairs had been placed along long stretches so people could sit down if they needed to. Visual signage was in place to direct people towards the toilets, dining room, lounges and outside space.

Good

Is the service caring?

Our findings

People told us staff were kind and compassionate. One person said, "staff are so patient and cheerful". Another person told us, "Staff are nice and I like them," and third person said, "You can talk to all the staff, they are so patient and helpful."

Relatives told us they were welcome to visit their family members at any time. One relative said, "Everything is good here, staff are pleasant and caring." Another told us, "[My relative] loves it here and all the staff. It's like a home from home." The home had a number of areas that family members could use to speak to their relative in private, including a coffee shop area where families and people who used the service could help themselves to coffee. The registered manager told us they did as much as they could so families felt at home when visiting their relatives. She told us people could use areas of the home to host special events, and told us relatives had recently used one of the lounges to host a wake for a person who used the service who had recently passed away. She said, "We want to do as much as we can for people. It's their home, so they should be able to have an anniversary party or have a group of family over, just like they could in their own houses."

Staff responded to people warmly. We observed staff offering support and reassurance to people if they were distressed. One staff member sat in the lounge holding one person's hand and talking with them for ten minutes. We saw people seemed relaxed and at ease with staff. Relatives told us staff knew people well. One relative said, "The staff know [My relative's] likes and dislikes and are good with her." Care records were personal. A document called 'My Life' contained information provided by the person and their family about their lives such as their personal history, interests, and preferences. This information helped staff to have an understanding of the person. For example we saw in one person's 'My Life' document they liked to have a quiet environment. This information had also been included in individual care plans such as their bathing care plan to ensure they were in a noise free environment whenever possible.

Information was provided for people. Each person had been given an information booklet about the home which explained the roles of key members of staff, how the home was run, and what people should expect. We saw information was also displayed, such as events which were planned and upcoming activities. Leaflets were displayed on noticeboards around the home about the needs of people with dementia. These leaflets were produced by the Alzheimer's Society and included information on areas such as nutrition, how to make dining experiences as positive as possible and about how people store and recall memories for people living with dementia. The information was presented in a way which was simple and easy to understand. The manager told us this information was provided so relatives were aware of good practice in dementia care and would have an understanding how staff and they should respond to people in a positive way.

The manager told us about plans to introduce records within people's bedrooms so people living with dementia had information about their care. The resource, known as 'My visitor book' was promoted by the Alzheimer's society, primarily to record visits from health professionals. The manager told us she was going to trial this using the resource to record visits people received from their relatives too. Relatives would be asked to record brief information about their visits, which staff could use as discussion topics when reminding people of who had visited them that day. The records were written in an 'easy read' format and as they were going to be kept in people's own bedroom so where people were able, they could look through these independently.

Relatives told us they were kept up to date with how their family members were. They told us they were contacted quickly if staff needed to let them know anything, such as if their relative was not well. One relative said, "The staff are really lovely, very helpful and keep me informed." Another relative told us staff had helped them to understand their family member's needs and how they needed to be supported, they said, "I hadn't been sure why [My relative] stayed in bed, but when I asked [Staff member's name] they explained straight away and clearly, very helpful. [My Relative] often refuses to get up saying he is tired and wants to stay in bed. I am happy they try to get him up, and he does get up now and again. He is kept clean and tidy and has no bed sores."

People told us staff treated them well and respected their choices and privacy. One person said, "I prefer to stay in my room most of the time but staff come in to see me and will do anything I want. They always knock on the door and keep my room clean and tidy." Another person told us, "I talk to the girls [staff] and they will do my hair and nails. I

Good

Is the service caring?

get a bath when I want one and my privacy is respected." A relative commented, "This is a nice home and [My relative] is looked after well. We bring beer in for him and he has a can every day."

People had been asked whether they wanted to make plans in advance about how they would like to be cared for at the end of their lives. These plans were very specific and individual to the person. All staff had undertaken training in end of life care which was a distance learning course, involving reading materials, completing assessments and taking part in discussion groups about good end of life care. Nursing staff were trained to use syringe drivers (a battery-powered pump that delivers a continuous dose of certain medicines) so people could receive the care they needed without having to go into a hospital. The manager told us that whenever possible they provided a room for families as people approached the end of their lives, so that they were able to rest, whilst still being close to their relatives.

Good

Is the service responsive?

Our findings

People told us staff met their needs well. One person told us, "The girls [staff] are very good. They know what I need so remind me to take my medicines when I need them. They seem to have everything covered." Another person stated, "I can have a bath when I wish, or a snack if I want."

During our inspection we overheard one person telling a staff member they didn't feel well. Staff responded to this person straight away, asking if they wanted to go to their room for a rest. Staff alerted the nurse on duty who checked the person to see if they could ascertain what was wrong. We spoke with this person's relative when they visited later in the day, they said, "I visit daily and the staff are so good. They keep me updated because [My relative] is not too well, but they are looking after her so well. She is always clean and tidy and is happy here."

Care plans and assessments were comprehensive and specific to the person receiving care. Pre admission assessments had been carried out with people and their families to determine their needs and the support they required from staff. A range of assessment tools had been used to determine what staff input people needed with mobility, nutrition and skin integrity. Where needs had been identified, care plans described to staff how they should deliver people's care. Care plans were reader friendly and jargon free. Clear information was presented in short sentences making the information easy to read.

We spoke with staff about the needs of the people whose care records we had reviewed, and observed the care delivered to them. All staff we spoke with told us they had read people's care plans and were able to clearly describe how they were cared for. Staff told us about the care they delivered to reduce the risk of one person, who was nursed in bed, developing pressure damage. They told us they helped the person to change position every two hours, and regularly checked their pressure relieving mattress was on the correct setting. The detail staff provided mirrored information in the person's care plan. Another person had diabetes and we saw the nurse checked their blood sugars, and administered insulin based on the blood sugar reading. The care we observed was delivered as per people's care plans.

Records kept, evidenced that people's planned care had been delivered. Where people had been assessed as requiring regular positional changes, or food and fluid monitoring, documentation showed this care had been provided. We looked at a selection of daily records and saw records had been well maintained.

People's needs were re-evaluated on a monthly basis, or where there had been a change in their planned care. Assessments had been completed monthly, and staff had recorded detailed information about how people had responded to their planned care and whether there had been any changes noted. Where people's needs had changed, care plans had been re-written to reflect these needs. For example when one person had lost weight their care plan had been re-written to indicate their weight should be monitored more closely by moving from weighing the person monthly to weekly. Information had also been included detailing the point when dietitians should be contacted if their weight continued to decrease.

The provider operated two homes on the same site, a full time activities coordinator was employed to work between the two homes. We observed a number of different activities sessions and saw people seemed to really enjoy the sessions. People and their relatives were very positive about the activities on offer and the coordinator. One relative said, "The new guy [activities coordinator] is brilliant. He's like a breath of fresh air, and seems born to do this kind of work." Visits were regularly planned outside the home using a minibus the service had access to. We spoke with the activities coordinator who told us the manager and provider were very supportive in enabling them to provide a wide range of activities for people. They told us they had an adequate budget to plan activities and events, and that this budget was negotiable for special plans or events. They said, "More or less anything I've requested has been agreed."

People and their relatives were invited to attend monthly meetings to discuss their views on how the home was run. The manager held a monthly manager's surgery, for three hours on an evening, so relatives could call in if they had any issues. Notes from these meetings showed they were not well attended. The manager said, "People know they can catch me at any time. I'm here until six most evenings anyway, and I have an open door policy. I think it's important to plan the surgeries, so if anyone didn't feel comfortable just knocking on my door, of if they had missed me once or twice, they know I'm scheduled to be there at a specific time to speak with them."

Good

Is the service responsive?

Questionnaires were sent annually to people who lived at the home and their relatives. Results from the survey had been analysed and shared with people during meetings. Of the 21 questionnaires sent out, 11 had been returned. Results were very positive. Comments included; “The level of care given to [My relative] is good and food looks to be good” and “My relative is well cared for and treated with respect.” Any of the negative responses were in relation to the laundry, and clothing items occasionally going missing. In response to this feedback domestic staff hours had been amended to allow them more time to spend on laundry duties, and a housekeeper was to be employed who would have responsibility for ensuring expected standards of domestic and laundry tasks were met. Information on how the satisfaction survey had been acted on had been shared with people during the residents meetings and through posters displayed in the home.

Complaints records were well maintained. There had been three complaints within the previous 12 months, and in addition to these formal complaints, minor issues had also been recorded to ensure these were responded to and addressed. Two relatives we spoke with told us they had recently made a complaint. They told us the registered manager had responded quickly to the concerns they had shared, and responded to them in writing detailing the steps they were taking to resolve the complaint.

Good

Is the service well-led?

Our findings

A registered manager was in post. The registered manager was present during our inspection and assisted us with our enquiries. People, their relatives and staff spoke highly of the manager. They told us she was available to speak with them whenever they needed to. One comment from a recent satisfaction survey stated, "The care home manager is caring and efficient and very approachable." One person's care manager told us the registered manager was proactive and competent in her role. They said, "On the times we've gone to her looking for a placement, perhaps with someone who can display behaviours that are challenging or that has a high level of need, she has been very happy to work with us. She's made suggestions and put things in place so that the home is ready to care for the person before they are admitted. I've always been really impressed. She seems to have everything under control."

The registered manager did not have a clinical background, but told us she was well supported by the provider organisation to deal with any issues of a clinical nature. She told us she worked closely with the registered manager of another of the provider's home who was a registered nurse, as well as being able to speak with the clinical lead for the provider if she needed any support. The manager had undertaken training in care delivery such as Venipuncture (the collection of blood from a vein) and they said, "I was the only non-clinical person on the training, but I want to keep on doing that kind of training so that I can provide support and observations for our nurses."

The manager told us she was well supported by the provider organisation, receiving visits and feedback from both the regional manager and the quality assurance manager. A number of quality checks were carried out within the home by a range of staff designations. We saw senior staff had completed documentation to show the checks they had carried out to ensure processes regarding health and safety, medicines and infection control were being properly followed. The manager reviewed care records to determine if expected standards of recording were being met. Where areas for improvement had been noted, actions had been detailed, and the audits had been reviewed the following month to confirm actions had been completed and signed off.

Representatives from the provider organisation also undertook checks and provided feedback on the quality of the service which was provided at the home. The regional manager visited monthly and prepared a report detailing their findings. They had observed staff practice, asked staff questions on specific policies and procedures, spoke with people who used the service and walked around the home noting their observations on the standard of accommodation.

The quality assurance manager also visited regularly completing a schedule of audits and monitoring. One in depth audit had been carried out in the style of a CQC inspection, where the quality assurance manager has assessed the home against the Key Lines of Enquiry which are inspection criteria which CQC inspect against.

We saw evidence that feedback from these provider visits had been put into place. The registered manager had gone through feedback from the provider's visits, and assigned any actions to a range of staff for them to take responsibility for improvement actions being carried out. The manager told us she thought it was important that all staff were aware and involved within improving the home, as it was all staff's responsibility to ensure standards were met. We saw evidence that improvement action had been carried out following provider feedback. A previous visit had noted that signage around the home should be improved, shortly after this visit visual signs had been purchased, and during our inspection we saw they were in place, directing people to bathrooms, lounges and outside space. Provider visit feedback highlighted that the controlled drugs register should be audited more frequently. We saw this had been discussed with nursing staff during supervision. We saw the provider visits included checking previous areas of action had been completed to ensure standards were maintained.

Healthcare professionals who visited the home, including GPs, opticians, a dentist, and district nurses had been contacted in April 2015 to ask for their feedback about the service and how it was operated. Responses had been positive, praising the service on the way they supported people at the home.

Staff told us they attended regular staff meetings where they were encouraged to share their feedback and suggestions for how to improve the home. Staff told us communication within the home was good. We observed a handover meeting which was well organised and detailed.

Good

Is the service well-led?

Staff were aware of their responsibilities and who they should contact for support out of usual office hours. They told us they could contact the manager or the provider at any point if they needed their support.

Processes were in place to keep up to date with research and best practice. The registered manager had attended training provided by Stirling University, a leading research organisation in dementia care. They also told us they had signed up to receive information about new innovation and developments in care practice from the Alzheimer's Society.