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Allingham House Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We undertook an inspection of Allingham House Care Centre, referred to as Allingham House, on 27 and 28 September. The first day of inspection was unannounced which meant the provider did not know we were coming.

We last carried out an inspection at Allingham House on 19 November 2014. We rated the service as good overall and the service was meeting legal requirements.

Allingham House provides nursing and personal care and accommodation for up to 86 older people, some of whom are living with a diagnosis of dementia. The home accommodates people over three floors with 82 single and two double rooms. There were 85 people living at the home on the day of our inspection.

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

The registered manager had kept us informed of safeguarding incidents and other notifiable events which had occurred in the home in line with their statutory obligations. Staff were confident in describing the different kinds of abuse and the signs and symptoms that would suggest a person they supported might be at risk of abuse. They knew what action to take to safeguard people from harm. All of the staff received regular training that provided them with the knowledge and skills to meet people's individual needs in an effective manner.

People's safety risks were identified, managed and reviewed and the staff understood how to keep people safe. There were sufficient numbers of suitable staff to meet people's needs and promote people's safety. Systems were in place to ensure the correct administration of medicines.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the registered manager understood when an application should be made and was aware of the principles of the Mental Capacity Act 2005. Staff sought people's consent before they provided care and support. However, some people who used the service were unable to make certain decisions about their care. In these circumstances the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were being followed. Where people had restrictions placed upon them to keep them safe, the staff ensured people's rights to receive care that met their needs and preferences were protected.

The service supported a high number of Jewish people and ensured all meals were Kosher in order to follow their beliefs. The layout of the kitchens supported the preparation and production of Kosher food in conjunction with the Jewish faith. All crockery, tableware and table linen reflected the type of meal being

served and this ensured people's cultural and religious needs were met with regards to the preparation of food.

The environment was designed to enable people to move freely around the floor of the home where they lived. There were lounges and dining areas on each floor of the home and a large activity room on the ground floor, with access to a large secure garden space. These areas were also used to enable people to participate in social events.

People were treated with kindness, compassion and respect and staff promoted people's independence and right to privacy. Mealtimes were pleasant experiences for people, and those who needed assistance were helped by staff in a discreet and calm manner.

People, relatives and other healthcare professionals involved with the service said that the support staff were caring. On the day of our visits we saw people looked well cared for. There was a relaxed atmosphere in the home. We saw staff engaging with people, speaking calmly and respectfully to people who used the service.

People's care plans contained mainly clinical information and focused on meeting care needs and dealing with risks. Information about their likes, dislikes and life histories was basic. However staff demonstrated they knew people's individual preferences and what they needed to do to meet people's care needs. The people we spoke with who were using the service, and visiting relatives, told us they were happy with the care provided.

Laminated care plan summaries were in all bedrooms. These documents provided care workers with a summary of people's care preferences including personal care routines, ways of communicating, favourite foods and activities they liked to do.

During our visit we saw examples of staff treating people with respect and dignity. Staff promoted people's independence by giving them choices. People using the service and their relatives were consulted and involved in assessments, care planning and the development of the service.

There were enough care staff on duty to meet people's support needs with bespoke staff employed for domestic, housekeeping and activity duties. People's access to activities was good; we saw some new ideas in the home with regards to activities. The service actively involved and welcomed family members to events held at the home, including a popular bistro evening.

Staff told us that they felt supported by the registered manager. Formal supervisions with staff had not occurred as frequently as stipulated in the company policy, however staff we spoke with felt valued and listened to. Regular team meetings were also held with incentives offered for staff to attend and staff were able to raise any issues or concerns at these meetings. Staff spoke highly of the management at the home.

There were systems in place to monitor accidents, incidents or safeguarding concerns within the home. The registered manager maintained a monthly record about the incidents which had occurred and what had been done in response. Appropriate action had been taken to address issues identified during these audits.

Feedback was sought in resident and relative meetings and used to improve the care. People knew how to make a complaint and complaints were managed in accordance with the provider's complaints policy. There was an on-going complaint at the time of our inspection and we saw what the registered manager had done to try to resolve this. The service was pro-active in addressing issues raised with them during this

inspection.

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

Safeguarding incidents were reviewed by the registered manager and there was a clear action plan in place. Monthly audits of safeguarding incidents were completed.

People told us there were enough staff available when they needed help and support. Staff responded to their needs in a timely manner.

There was a robust recruitment and selection process to ensure staff recruited had the right skills and experience to meet the needs of people who lived in the home.

Is the service effective?

Good

Some staff had received supervision sessions but these were not in line with company policy, as not every employee had received bi-monthly supervisions. Staff, however, felt supported and suitably trained for their roles.

The service supported a high number of Jewish people and ensured all meals were Kosher in order to follow their beliefs.

The home had a good relationship with health professionals and was effective in responding to deteriorations in people's health and involved other professionals in strategic reviews of care.

Is the service caring?

Good

We saw that people's privacy and dignity were respected and staff provided us with examples as to how they achieved this.

The service employed housekeepers to serve food. People were assisted at meal times by care workers, who were discreet and engaged with the individual they were supporting.

Care workers sought consent from people where possible before undertaking care tasks and were kind and caring in their approach.

Is the service responsive?

Good

The service responded to changing needs and made referrals to relevant health professionals to ensure people's safety and wellbeing.

People's spiritual needs were met with trips to a local synagogue and a chaplain from the local community had responsibility for religious aspects of the home. All faiths were catered for and we saw plans in place to celebrate annual Jewish and Christian festivals.

Staff knew the people they were supporting very well. People were offered and made choices about their daily lives and the support they received.

Is the service well-led?

Good

We received positive feedback about the leadership within the home from people who used the service, their relatives and staff. The registered manager received good support from the deputy manager, quality assurance manager and the regional director.

There were systems in place to monitor accidents, incidents or safeguarding concerns within the home. The registered manager maintained a monthly record about the incidents which had occurred and what had been done in response.

The registered manager had kept us informed of safeguarding incidents and other notifiable events which had occurred in the home in line with their statutory obligations.

Allingham House Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 27 and 28 September 2016 and was unannounced on the first day. The inspection team included two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection one inspector from the inspection team was on site.

Before the inspection we gathered and reviewed information we held about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider.

We contacted the local Healthwatch organisation and the local authority commissioning team to obtain their views about the provider. No concerns were raised about the service provided at Allingham House. We liaised with other professionals involved with the service at the time of our inspection and received complimentary feedback about management and staff.

We spoke with 11 people who used the service, seven visiting relatives, two visiting healthcare professionals and 12 members of staff, including the registered manger, the deputy manager and the chef. We observed the way people were supported in communal areas and looked at records relating to the service.

Some people who used the service were unable to tell us about their care therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who cannot tell us about their care. We observed care and support at

lunch time in the dining rooms and also looked at the kitchen, the laundry, a number of people's bedrooms and the outside space available for people using the service.

We reviewed five people's care records in detail. We looked at four staff recruitment files and nine records in relation to staff training, supervisions and appraisals. We looked at the systems and processes in place for monitoring and assessing the quality of the service provided by Allingham House and reviewed a range of records relating to the management of the service; for example medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, safeguarding records, policies and procedures, complaints and compliments.

Good

Is the service safe?

Our findings

When we spoke with people living at Allingham House they told us they felt safe and well cared for. No one we spoke with raised any concerns about how staff treated them. When asked if they felt safe people told us, "Yes, I'm safe. It's the next best thing to home." People were provided with a pendant to wear around their neck so that help could be summonsed quickly if there was ever a need, for example following a fall to the floor. One person told us, "I feel safe with this – though it's not used a lot." A relative we spoke with also told us, ""My family member is safe; I've never had a problem."

The registered manager told us that a dependency tool was used to calculate direct care hours required each week, based on the needs of the people living in the home. On the days of our inspection there were enough staff on duty to meet people's needs. People we spoke with told us there were enough staff available when they needed help and support. People told us that staff responded to their needs in a timely manner. One person we spoke with told us, "Staff are on tap," and we saw that call bells were attended to in a timely manner throughout the inspection.

We looked at the staff rotas to check staffing levels were consistent and they were. The home also employed domestic staff to clean the home and housekeepers to assist at meal times on all floors of the home. This meant that care staff were not undertaking additional duties and were available to attend to people requiring assistance with personal care needs. People using the service could be reassured that they would be kept safe, being supported by adequate numbers of staff.
We looked at the care records for five people who used the service. Care records contained individualised risk assessments and risk management plans and we saw that risks had been discussed with either the person or their relative. Care plans contained detailed guidance for staff to follow to minimise risks for people. We saw risks in relation to the use of bed rails, the use of hoists, falls and eating and drinking.

For example, one person had required the use of a stand aid for transfers but their health had recently deteriorated. The service had reviewed the use of the stand aid and found it to be no longer safe. This persons needs were reassessed and it was found that a full body hoist was now required. We saw the person's risk assessment and care plan had been updated to show this and staff we spoke with confirmed they were aware of the changes in need. Detailed risk assessments meant that there was a robust risk assessment and management strategy being followed to keep people safe from accidental harm.

As part of our inspection, we make sure the service administers, stores and disposes of medicines appropriately. We observed medicines being administered and saw the staff member asking the person if they wanted their medicine and confirming what they were about to be given. We looked at five medication administration records (MARs) and saw they had all been completed as required, with the correct letter being recorded in the box when the person had refused the medicine. Most medicines were delivered to the service in pre-sealed blister packs, however we saw that some medicines which were required as and when (PRN) were kept as 'named' stock and arrived boxed.

These medicines had been checked into the service by two staff members who had signed and recorded the

quantity received. We saw medicines had been audited and all medicines had been accounted for. Where we found there to be additional tablets within one box of stored medicines, we saw the staff member in charge took immediate action to address this, and reduce the risk of it happening again. The service informed CQC that this was a counting error that had not been identified and provided evidence to this effect.

Each person had an up to date photograph on the front of their MARs, to assist staff with ensuring the correct person received the right medicines. People who required their medicines to be administered as and when required (PRN), had a protocol kept with their MARs. People who required their medicines to be administered covertly had a best interest decision recorded, as well as documentation showing the persons GP and family members had been consulted prior to a decision being made.

Some people living at Allingham House, required medicines known as controlled drugs. Controlled drugs require additional checks to be completed and are required to be stored separately in a secure unit. We saw that two members of the nursing staff, one from the day shift and one from the night shift, checked the controlled drugs at the start of each shift. This showed the service was ensuring their medicines were being stored and administered safely.

A system was in place to record all accidents and incidents, such as falls. The registered manager told us that the outcomes of accidents and incidents were analysed to see what lessons could be learnt and reduce future risk by taking preventative action. For example there was incident where a person living at Allingham House, was given something to eat which contained an ingredient they were allergic to. Since this incident, the service had taken additional steps by ensuring all handover sheets had the allergy documented, there was a photograph of the person and any allergy recorded outside of the kitchen. This showed that when an incident occurred the service had taken appropriate action to prevent it from happening again.

We saw that the service was responding to safeguarding concerns appropriately. Where there had been a recent incident involving a staff member we saw the service had taken appropriate action by contacting the local authority and family members as well as notifying the Care Quality Commission (CQC). They had collected statements and had taken appropriate action to prevent this occurrence from happening again.

Any safeguarding incidents were reviewed by the registered manager and there was a clear action plan put in place. We saw monthly audits of safeguarding incidents were completed. One of these audits had identified an increased number of incidents on a specific floor occurring on an afternoon. We saw that the registered manager had taken action by increasing the number of staff working on that floor in the afternoon. A care worker we spoke with confirmed that there were now five care staff on the residential unit all morning and all afternoon. Previously only four care workers had been on shift in the afternoon. Since the introduction of an additional staff member on rota we saw that the number of incidents had reduced on that particular floor.

We looked at four recruitment files and found the provider followed a robust recruitment and selection process to ensure staff recruited had the right skills and experience to meet the needs of people who lived in the home. Personnel files were in good order. The correct paperwork was on file in relation to the recruitment process and recruitment records for staff included proof of identity, two references and an application form. Disclosure and Barring Service (DBS) checks were in place for those employed by the service. DBS checks help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services. We saw that where appropriate a DBS risk assessment had been undertaken by the service. This meant that people who used the service could be confident that staff appointed were suitable to work with vulnerable people.

Each person had a personal emergency evacuation plan (PEEP) which identified the assistance and equipment they would need for safe evacuation in the event of an emergency, for example a fire. We saw evidence of regular unannounced fire drills and staff we spoke with were able to outline the fire evacuation process. A white board in the foyer indicated those staff who were nominated fire marshals and whether they were in or out of the building. We were assured that people would be appropriately supported in the event of an emergency.

We saw ancillary staff, such as cleaners, laundress and maintenance, going about their duties in a friendly and professional manner. People spoke very highly about the cleanliness of the home. When asked about this, one person told us, "It's always clean; absolutely spotless." During both of our visits we noted that the environment was clean and fresh smelling, with no apparent odours. We saw measures in place to prevent cross-contamination and promote good infection control, including knee-operated hand washing facilities situated in the porch entrance area of the home for use by relatives, professionals and other visitors. We saw the activities co-ordinator handling the home's pet rabbit and showing some residents the rabbit. After returning the rabbit to the garden the staff member then followed a rigorous hand washing regime. This prevented the possibility of cross infection and promoted good infection control.

Good

Is the service effective?

Our findings

People at Allingham House received effective care and support which took account of their wishes and preferences. People and their relatives were very complimentary about the staff. One person we spoke with told us, "I was amazed at the warmth of the reception when I arrived."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the correct assessments in relation to capacity and decisions to restrict someone's liberty had been followed. Staff had received training in the MCA and followed the basic principle that people had capacity unless they had been assessed as not having it. The registered manager had a good understanding of the Mental Capacity Act and was aware of their responsibilities.

We saw some good examples of how the service was following the principles of the MCA. We saw that where people could consent to care the resident had signed the care plan accordingly. Where this was not possible care plans contained best interest decisions made in line with the MCA 2005 and in consultation with relatives and other health professionals.
For example, one care plan we look at contained information about the administration of covert medicines, including a letter on file from the GP to confirm this had been discussed with family members and was considered to be in the person's best interest. This meant the home understood how to protect the rights of the people they supported.
We looked at how staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Allingham House. We saw from training records that staff had completed an induction programme at the start of their employment. This meant that staff understood their roles and responsibilities within the home and as part of the team.

We examined the training records and spoke with six staff about the training on offer. Training records showed that staff did mandatory aspects of e-learning training, for example safeguarding, medicines, health and safety and infection control, and these were up-to-date. We saw and staff told us that they were also offered more specific training, for example in challenging and positive behaviour, dignity and dementia awareness. Personal development of staff was encouraged with NVQ's and we saw that 90% of staff had a Level 2 qualification. The service had also fostered good links with the local college through the apprenticeship programme. This meant that people were supported by suitably trained and competent staff.

We could see that some staff had received supervision sessions but these were not in line with company policy, as not every employee had received bi-monthly supervisions. Staff we spoke with told us that if a supervision was requested this would be undertaken by line managers. They told us that support from managers was on going and feedback was provided on a daily basis. They felt fully supported by managers despite the lack of formal supervisions and felt any concerns they brought up would be responded to. The service acknowledged that the regularity of supervisions with staff had slipped and informed us that this would be addressed. We will check on progress of this aspect at the next inspection.

The service supported a high number of Jewish people and ensured all meals were Kosher in order to follow their beliefs. This was documented within people's care plans. We met with the chef and saw the layout of the kitchens, with specified milk, neutral and meat areas, for the preparation and production of Kosher food in conjunction with the Jewish faith. The service had recognised the need to have separate sets of dishes for dairy products and meat and had purchased white crockery with different coloured rims, red and blue. These were used at different meal times and we saw that all tableware and table linen reflected the type of meal being served. By doing this the service ensured people's cultural and religious needs were met with regards to the preparation and serving of food.

People we spoke with expressed satisfaction with the food and drink provided in the home.
Relatives we spoke with were complimentary about the food and told us, "[Name] likes their meals. They're very good." We spoke with a person at lunch time who told us, "Everybody is asked what they would like to have. I enjoy it. "

Residents were consulted about menus during resident's meetings and the chef told us that any comments were taken into account when planning menus. We saw information was available for the chef and displayed in the kitchen in relation to the consistency of food for people and we spoke with the chef who told us about the special diets which were catered for, for example diabetic and fork-mashable diets. They were also provided with information relating to people's specific allergies. People's care records we viewed showed that people's nutritional needs were assessed and monitored to ensure their wellbeing.

We checked to see that the environment had been designed to promote people's wellbeing and ensure their safety. We saw signage and pictures on toilet and bathroom doors, including to
en-suites, to assist people with dementia to orientate around the home. We saw that the service had placed large laminated arrows above two doorways to help two individuals orientate to their own bedrooms. This helped to maintain their independence. The activities room was signposted and access to the garden was clearly marked. We saw that people's bedrooms were personalised with family photographs, ornaments and small items of furniture, such as a favourite chair or a side table.

People's care records showed that their day to day health needs were being met. People had access to a GP and district nurses visited the service on a regular basis to undertake routine treatments, such as administer insulin, change dressings and take bloods.

The home had a good relationship with health professionals, in particular with a hospital consultant physician in elderly medicine. We saw that the consultant visited the service at least once a month, met with families and reviewed patients in their care or identified to them by the service. For example, we saw that the physician had seen nine residents in the last three visits, some of whom were identified by the home as needing a review of care due to them having an increased number of falls. This meant that the service was effective in responding to deteriorations in people's health and involved other professionals in strategic reviews of care.

Good

Is the service caring?

Our findings

People and their relatives were very complimentary about the service and the calibre of staff supporting people living at Allingham House. People told us, "Staff are great, helpful and caring" and, "I can't say a bad thing about here." A relative we spoke with commented, "I wouldn't have (person) anywhere else."

On the initial tour around the home we saw nameplates on bedroom doors. As well as displaying people's names the nameplates had small stickers in one corner, displaying a ladybird, a butterfly, both or none. These stickers denoted people's preferences in the event of a medical emergency and meant that the person had either opted not to attend hospital, not to be resuscitated or both. The stickers made it clear to staff what people's wishes were and we saw that these were also replicated on the front of care plan files. This meant that important advanced clinical decisions made by people and their families were conveyed in a discreet and dignified way.

The home was also part of the six step end of life programme. The six step programme aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. This demonstrated that the service recognised the importance of end of life care and making plans in advance so that people could be supported to choose where they died.

There was a nice, relaxed atmosphere in all areas of the home. We spent time observing people in the lounges and dining areas of the home and watched the activities that were going on. We saw that people were respected by staff and treated with kindness. We observed staff treating people affectionately and heard staff speaking in a friendly manner. Staff displayed respect and admiration for people using the service and we saw that trusting relationships had formed.

As the service employed housekeepers to serve food, care workers were then available to provide assistance when necessary. We observed people being supported to eat appropriately by care workers, who were discreet and engaged with the individual they were supporting. We found the mealtime experience was unhurried and relaxed, with appropriate music playing in the background and people chatting to each other or staff.

We saw that people's privacy and dignity were respected and staff provided us with examples as to how they achieved this. One care worker told us they closed all doors, blinds and curtains and turned the green light on before providing personal care. This light was displayed in the corridor and informed other care workers that personal care was being delivered in the room and prompted them not to enter the room. This meant that people's dignity was preserved when receiving personal care.

Small whiteboards in dining areas on all floors of the home displayed details of people's specific diets. We saw that small roller blinds had been fitted above each board. Staff were able to refer to the information if required during meal times but we saw the blinds were lowered after these times. This meant that people's dietary information was kept private and the dignity of individuals was preserved.

We spoke with a member of staff on the second day of the inspection. They were aware of their role and responsibilities and were able to describe the needs of individuals who used the service. The care worker told us how one person liked to wear make-up and said, "I always make sure she has make-up on. She has a make- up bag." This demonstrated the care worker's knowledge of an individual and gave us an example of how they respected people's rights and wishes.

We heard care workers explaining to people what they intended doing and obtained permission from individuals before carrying out any tasks. We saw good examples of this during our lunch time observations. We heard care workers assisting people with eating telling them what the food on offer was. Staff were patient in their approach and checked that people were ready to continue with eating. We also heard a senior care worker offering breakfast medicines to a person and explaining what the medicines were for when asked. This meant that care workers sought consent from people where possible before undertaking care tasks and were kind and caring in their approach.

Good

Is the service responsive?

Our findings

People we spoke with were complimentary about the service. Relatives told us, "They work very hard to keep people interested." Another added, "We're very happy with the way things are."

Care plans we looked at confirmed that a detailed assessment of needs had been undertaken by the registered manager, a deputy manager or a nurse before people were admitted to the service. We reviewed whether the care plans were written in a person-centred way. Person-centred care indicates care is specific to the individual concerned. The provider used person-centred plans to support and involve people to make decisions about their care and their lives overall.

We looked at five care plans during our inspection. We saw that care plans contained detailed clinical information, including identified risks, but information relating to people's preferences and life histories was basic. Staff we spoke with were aware of people's preferences and life histories as they listened and chatted with them about the things that were of interest to them.

Where someone was at risk of falling out of bed, we saw the service had consulted with them and assessed them for bed rails in order to minimise the risk. Where one person had been admitted to the service with pressure sores, we saw the service had sought appropriate advice and involvement from the tissue viability nurse as well as ensuring the person was being cared for on the correct pressure relieving equipment. We saw that a wound care plan had been formulated, reviewed at regular intervals and then stopped once the wound had healed. One family member told us, "My relative receives all the support needed; staff are always popping in and out." This demonstrated that the service responded to changing needs and made referrals to relevant health professionals to ensure people's safety and wellbeing.

We saw laminated care plan summaries in all bedrooms. These documents provided care workers with a summary of people's care preferences including personal care routines, ways of communicating, favourite foods and activities they liked to do.

During the first day of inspection we spoke with visiting relatives who told us that their relative had been woken up by a member of the night staff one morning. They told us the person's preference was to lie in bed until 7.15am, before being woken for a shower. We discussed this with the registered manager at the end of the first day of inspection who assured us this would be investigated. On the second day of inspection the laminated care plan summary had been amended to reflect the person's preference and an entry made into the diary so that all staff were aware. We were assured that this had been an isolated error by a new member of staff. This demonstrated that the service was responsive to the preferences and choices of individuals and communicated these appropriately to staff.

We spoke to staff who were able to confirm people's preferences. Staff knew the people they were supporting very well. We heard throughout the inspection examples of people being given, and making, choices about their daily lives and the support they received.

One care plan we viewed noted an individual's preference for female carers when receiving personal care. This was reflected on the care plan summary in the person's bedroom and staff we spoke with on that floor were aware of the person's wishes. This meant that people were actively empowered in making decisions about any changes to their care if they had the capacity to do so and the service respected these decisions.

The home employed four people in an activities co-ordinator role and we met with one who was on duty at the time of our inspection. The home had a large room with a conservatory nominated for activities and this provided residents with access to a large, enclosed rear garden. This was well used by residents and relatives during the warmer months and photographs displayed confirmed this.

The home utilised information technology to good effect with regards to the provision of activities. There was a computer available for use on each floor with photographs of trips, entertainment and activities displayed electronically on a screen in the foyer. The service had purchased a train ride journey activity and we saw a 60-inch TV screen sitting where the train window should be, playing footage from a real train journey. A table was nicely set to recreate an old style train carriage, meaning residents as 'passengers' could sit and watch the English countryside roll by.

The activities co-ordinators and other staff were enthusiastic about the role they played in engaging people in activities. We saw that people had been taken on various trips over the summer to local places such as markets, the airport and a garden centre but also further afield to Chester Zoo and Blackpool. People's spiritual needs were met with trips to a local synagogue and a chaplain from the local community had responsibility for religious aspects of the home. All faiths were catered for and we saw plans in place to celebrate annual Jewish and Christian festivals. The home also held regular bistro evenings where relatives could join family members and eat in a restaurant-type setting. These were popular events, often fully booked due to the limited number of tables available.

A monthly magazine was distributed by the service and featured stories, interviews with residents, past and future trips and other forthcoming events. This meant that people and their relatives were kept informed about what was on offer at Allingham House.

The service sign-posted people to advocacy services and made referrals to best interest assessors where appropriate. We spoke with a best interest assessor who had had recent involvement with the home and some residents. This had been a positive experience and the assessor told us that, in their opinion, the home supported people well.

We brought two incidents that occurred on the residential unit during our inspection to the attention of the registered manager. One person had displayed some aggressive behaviour to a care worker. Other staff reacted calmly to this, diffused the situation and supported the person appropriately away from the situation. This was not the only incident involving the individual that had occurred and this feedback was provided to management. The home involved relevant family members and consulted with health professionals and it was deemed to be in the person's best interest to relocate them to the nursing unit. This meant that the person would receive additional support and supervision due to increased staffing levels on the unit and health and wellbeing input from qualified professionals. This demonstrated that the service was responsive in addressing incidents that were brought to their attention, whilst acting in a person's best interests.

We saw that one complaint was on going at the time of our inspection. We saw the registered manager was trying to arrange to meet with the complainant at a mutually convenient time. We saw that other complaints were logged and dealt with according to company timescales. A concern was raised with us on the second

day of inspection in relation to a lack of one to one activities and we were provided with evidence that one to one activities were documented for all who participated. We were assured that people using the service felt comfortable with all levels of senior management in the company. If they felt it necessary to make a complaint they were confident that this would be addressed.

We saw many examples of positive feedback sent to the home in the form of thank you cards, letters and compliments sent via email. We saw examples of compliments from relatives of people using the service, from visiting professionals and members of the community.

Good

Is the service well-led?

Our findings

We received positive feedback about the leadership within the home from people who used the service, their relatives and staff. It was clear that people had confidence in the manager and that they were a regular presence in the home. One visiting relative we spoke with told us, "The registered manager is always here; always cheery. No cause for complaint." Another told us, "Management is great and so are all the staff."

All staff felt valued and supported by the registered manager and other senior staff. When asked their opinion about the management of the service staff members told us they were always approachable and fair and said, "If I've got anything to say then they will listen.". It was apparent that staff had confidence in the registered manager and acknowledged their ability to manage the service.

There was a clear management structure in place and the registered manager had a hands on approach. The registered manager and deputy manager covered shifts on occasions so that the need for agency staff was avoided. This meant that people were supported by staff who knew their capabilities and personal care needs.

Through speaking with the staff team, people who used the service, and the registered manager it was clear there was a strong cohesive team. It was apparent that staff enjoyed their work and one member of staff we spoke with confirmed this and said, "I like working here. I like making a difference." This meant people who used the service could be confident the service they received was a good one.

Staff told us that staff meetings occurred on a regular basis. We saw minutes of these meetings and topics for discussion included moving and handling, infection control, laundry and administering medicines. Staff meetings were held twice on the same day to give staff opportunity to attend one of the meetings. Incentives were available for those who attended staff meetings, as well as payment if attending in their own time. Staff we spoke with felt rewarded by management and told us, "They always say thank you; you feel appreciated."

There were systems in place to monitor accidents, incidents or safeguarding concerns within the home. The registered manager maintained a monthly record about the incidents which had occurred and what had been done in response. Audits were in place, for example in relation to falls, health and safety and medicines administration and any identified errors or actions had been addressed. We saw that competency assessments had been undertaken on senior care assistants qualified to administer medicines and we were assured that people had the necessary skills and knowledge for the task.

Audits were completed in relation to any safeguarding incidents. These were completed monthly and then reviewed to determine if there was a pattern to the incidents. We saw the service had taken action to minimise the risks to people, as staffing levels had been increased on one floor. This meant there were well-managed systems in place to monitor the quality of the care provided and quality audits were completed in line with company policy.

In conversation with the registered manager it was evident that they fully understood their responsibilities. The registered manager had kept us informed of safeguarding incidents and other notifiable events which had occurred in the home in line with their statutory obligations. The registered manager told us they received good support from the quality assurance manager and the regional director. They described their plans for the continual development of the service to ensure that the changing needs of people would continue to be met through quality care and support. We saw ideas on improving the environment for those with dementia in progress during our inspection, with the addition of a post office wall feature with a real post box, to the ground floor.

Previous to our inspection the registered manager had submitted applications to The National Dementia Care Awards for the home to be considered in three categories. The awards celebrate those providers striving to achieve excellence for people with dementia. At the time of our inspection the home were notified of their success in being one of five finalists in the category Best Resident and Relative Contribution.

The company used various ways to obtain feedback from people using the service and their relatives so that the service could continuously improve. Resident and relative meetings were held and minutes reflected the input from people using the service. The service encouraged people and their relatives to review the service on carehome.co.uk and feedback forms were made available in the home. At the time of our inspection the home were scoring 9.7 out of a possible 10 on the website with 42 out of 46 reviewers extremely likely to recommend the home to others.