North East Care Homes Limited

Stainton Way

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 26 and 28 July 2016. The first day of the inspection was unannounced which meant the registered provider and staff did not know we would be visiting. The second day of inspection was announced.

Stainton Way is a residential home situated in Hemlington. It provides accommodation for people who need assistance with personal care or people who may be living with a dementia. Stainton Way can accommodate up to 67 people in rooms that have en-suite facilities. The home is a purpose built building with surrounding gardens and car parking. It is close to local bus routes. At the time of inspection there was 62 people using the service.

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

People and their relatives told us they felt safe. Risk assessments were in place for people who needed these, however, some risk assessments had not been regularly reviewed and some required updating.

Accidents and incidents were monitored to identify any patterns and appropriate actions were taken to reduce the risks. Falls were also monitored to identify if any trends were occurring.

Staff we spoke with understood the procedure they needed to follow if they suspected abuse might be taking place and the registered provider had a policy in place to minimise the risk of abuse occurring. Safeguarding alerts had been raised or incidents accurately recorded if a referral to the local authority was not needed.

Emergency procedures were in place for staff to follow and personal emergency plans were in place for everyone. A robust procedure for recording fire drills had been implemented.

Medicines were managed appropriately. The registered provider had policies and procedures in place to ensure that medicines were handled safely. Medication administration records were completed fully to show when medicines had been administered and disposed of. People we spoke with confirmed they received their medicines when they needed them.

Certificates were in place to ensure the safety of the service and the equipment. Maintenance and fire checks had been carried out regularly.

A safe recruitment process was followed to reduce the risk of unsuitable staff being employed. All new staff

completed a thorough induction process with the registered provider.

Staff performance was monitored and recorded through a regular system of supervisions and appraisal. Staff had received training to support them to carry out their roles safely; however some training had expired and was overdue and some certificates were not available in staff files. These certificates were produced following the inspection. A training plan to ensure all staff had up to date training had been developed.

People were supported to maintain their health. People spoke positively about the nutrition and hydration provided at the service. Staff understood the procedures they needed to follow if people became at risk of malnutrition or dehydration.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and knew what action they would take if they suspected a person lacked capacity. However, documentation was not always in place to support best interest decisions.

Each person was involved with a range of health professionals and this had been documented within each person care records. From speaking with staff we could see that they had a good relationship with health professionals involved in people's care. People's care records contained evidence of appropriate referrals to professionals such as falls team, tissue viability nurses and dentists.

The service was clean and neutrally decorated throughout but was not always adapted to support people living with a dementia. People were able to bring their own furniture and personalise their bedrooms.

People spoke highly of the service and the staff. People said they were treated with dignity and respect.

People, and where appropriate their relatives, were actively involved in care planning and decision making. This was evident in signed care plans and consent forms. Information on advocacy was available and displayed throughout the service.

Care plans detailed people's needs, wishes and preferences. However, some care plans lacked person centred information in areas such as best interest decisions. The manager told us that all care plans were to be reviewed so they have a consistent level of detail. Care plans had been regularly reviewed and we saw evidence that relatives had been invited to these reviews.

The registered provider employed two activities coordinator. We saw a range of activities that were on offer; however, on the day of inspection we saw no organised activities taking place. We did see people helping the activities coordinator, watching television and speaking with staff. People were able to tell us about the activities on offer and told us they enjoyed the activities provided.

The registered provider had a clear process for handling complaints. There had been two complaints received in the past twelve months which had been managed appropriately. A copy of the complaints policy was displayed in the reception area of the home. People we spoke with confirmed they knew how to make a complaint.

Staff told us they enjoyed working at the service and felt supported by the management and that standards had been significantly improved by the manager. Staff told us they were confident any concerns would be dealt with appropriately. We could see from our observations and speaking with people that the manager had a visible presence at the service.

Feedback was sought from people, relatives, staff and visiting professionals. Feedback questionnaires had recently been sent to people and relatives. The manager told us this information would be evaluated and action plans produced where needed.

The service worked with various healthcare and social care agencies and sought professional advice to ensure that the individual needs of people were being met.

The manager understood their role and responsibilities and was able to describe when they would be required to submit notifications to CQC.

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.

Risk assessments were in place for people who needed these.

Staff we spoke with understood the procedure they needed to follow if they suspected abuse might be taking place. Safeguarding alerts and incidents had been accurately recorded.

A safe recruitment process was followed to reduce the risk of unsuitable staff being employed. All new staff completed a thorough induction process with the provider.

Medicines were managed appropriately. The provider had policies and procedures in place to ensure that medicines were handled safely.

Is the service effective?

Good

The service was effective.

Staff performance was monitored and recorded through a regular system of supervisions and appraisal.

Staff had received training to support them to carry out their roles safely. Robust plans were in place for any training that needed refreshing.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to maintain their health. People spoke positively about the nutrition and hydration provided at the service.

Is the service caring?

Good

The service was caring

People spoke highly of the staff and said they were treated with dignity and respect

Staff were knowledgeable about the likes, dislikes and preferences of people who used the service.

Care and support was individualised to meet people's needs.

Is the service responsive?

Good

The service was responsive.

People, and where appropriate their relatives, were actively involved in care planning and decision making.

People were able to tell us about the activities on offer and told us they enjoyed the activities provided.

The service had a clear process for handling complaints. People we spoke with confirmed they knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

Quality assurance processes were in place and regularly carried out to monitor the quality of the service.

Feedback from people who used the service, relatives and staff was sought.

Regular staff meetings had taken place and staff told us they were supported and included in the service.

Staff had taken appropriate action to raise concerns to the local authority safeguarding team when required.

Stainton Way

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 registered provider is meeting 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 of the service under the Care Act 2014.

This inspection took place on 26 and 28 July 2016. The first day of the inspection was unannounced which meant the registered provider and staff did not know we would be visiting. We informed the registered provider of the date of our second day visit.

The inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed information we held about the service, including notifications we had received from the registered provider. Notifications are changes, events or incidents the registered provider is legally obliged to send us within required timescales.

The registered provider had completed a provider information return [PIR]. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted commissioners of the relevant local authorities and local authority safeguarding team to gain their views of the service provided.

We spoke with twelve people who used the service and five relatives. We spent time in communal areas and observed how staff interacted with people. We looked at all communal areas of the service and bedrooms, with people's permission.

During the inspection we reviewed a range of records. This included four care plans, medication administration records (MARs), handover sheets and other documents relating to the day to day running of

the service. We spoke with seven staff members including the manager, deputy manager, a senior carer and four carers. We looked at four staff files which included recruitment and training records.

Good

Is the service safe?

Our findings

We asked people if they felt safe living at the service. Everyone we spoke with confirmed they felt safe. One person said, "Yes, I do feel safe. I suppose I have never really thought about it before but yes, I feel safe." A relative we spoke with told us, "Oh yes, I am confident [relative] is safe. They treat me very well when I visit too."

We looked at arrangements for managing risk to ensure people were protected from harm. Risks to people were assessed and care plans put in place to reduce the risk of them occurring. Where a risk was identified further assessments took place to assist in taking remedial action. For example, a risk assessment for one person showed they were at risk of falls. This led to a moving and handling care plan being produced. Another risk assessment detailed a person who was at risk of malnutrition. As a result a nutrition care plan had been developed and staff were monitoring and recording food and fluid intake. The service used recognised tools such as the Malnutrition Universal Screening Tool (MUST) and the Braden Scale to assess risks to people. MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition (undernourished), or obese. It also includes management guidelines which can be used to develop a care plan. We could see risk assessments had not always been reviewed on a monthly basis, following the registered providers procedure. However, all the risk assessments we looked at reflected the persons current needs.

We looked at arrangements in place for managing accidents and incidents and what actions were taken to prevent the risk of reoccurrence. Records were in place to show that accidents and incident were reviewed on a monthly basis by management who checked to see if there were any repeated patterns of accidents or incidents. Appropriate forms were completed for each accident or incident that had occurred. We spoke with staff who were knowledgeable about what action they would take if a person was suffering regular accidents, for example making referrals to other professionals such as the falls team.

Personal emergency evacuation plans (PEEPs) were in place for each person who used the service. PEEPs provide staff and emergency services with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. The PEEPs contained information about what assistance would be required and other considerations, such as medical conditions, that would need to be considered to evacuate someone safely. We could see that PEEPs were reviewed and update when needed.

Risk assessments were in place associated with the day to day running of the service. Regular checks were made by the maintenance staff in areas such as water temperature, emergency lighting, window restrictors and fire alarms. Required test certificates in areas such as electrical testing, controlled waste, legionella and fire fighting equipment were in place.

Records showed that regular fire drills were taking place for both day staff and night staff. A thorough record of the fire drills that had taken place were recorded and we could see different scenarios had been used on each fire drill that had taken place. The document recorded any issues that had been raised during the fire drill and what could be done to improve the process in the future.

All staff spoken with had a good level of knowledge and understanding of safeguarding and the different types of abuse. They were able to tell us procedures they would follow should they suspect abuse. An up to date safeguarding policy was available and displayed in the reception area of the home. We looked at training records in relation to safeguarding training; eight staff members had not received training in safeguarding and a further twelve staff members required refresher training in this area. We spoke with the manager about this who was able to show us a comprehensive training plan was in place to ensure all staff received training in this area.

We looked at records relating to safeguarding. We could see that referrals had been made to the local authority and recorded appropriately.

Staff told us they would not hesitate to whistle blow (tell someone) regarding any concerns they had. One staff member told us, "I would not hesitate to report anything to my manager or senior. I know it would be dealt with in confidence". Another staff member told us, "I think all staff here would whistle blow and I would have no problem doing it if I had concerns."

Systems were in place for the safe management of medicines. People's use of medicines was recorded using a medicine administration record (MARs). A MAR is a document showing the medicines a person has been prescribed and the recording when they have been administered. All of the MARs we looked at contained a photo of the persons. A photo helps staff to ensure they are administering medicines to the right person.

We reviewed ten people's MAR's and saw there were no gaps in administration. Where medicines had not been administered the reason for this had been recorded. A list of staff signatures for those staff administering medicines was stored in the front of the MARs. This helped create a clear record of who was administering medicines.

Medicines were stored securely in a locked medicines trolley. When they were not being used for medicine rounds they were stored securely in a locked cupboard. Room and fridge temperatures were recorded twice each day to ensure medicines were stored at the correct temperature. Regular audits had been completed to ensure room and fridge temperatures were recorded.

Stock checks of medicines were carried out every month to ensure people always had access to the medicines that they needed. Surplus medicines were securely stored until they could be returned to the pharmacist for safe disposal. Some people were prescribed controlled drugs. These are governed by the Misuse of Drugs Legislation and have strict control over administration and storage. We could see that they were securely stored and were audited on a daily basis.

The home had a medication policy in place which staff understood and followed.

A dependency tool was used to calculate safe staffing levels based on people's level of dependency and this was reviewed on a monthly basis. The manager told us they had increased staffing levels since starting at the service and they now 'over staffed' by one carer each shift. During the day, there was one team leader, one senior carer and four carers. At night there was one senior carer and five carers. The deputy manager told us they had bank staff who could provide cover during planned absence and when sickness occurred. They explained that the service liked to have 10% of staff who are bank staff so they had adequate cover at all times.

People we spoke with confirmed there was enough staff on duty day and night. One person we spoke with told us, "Things have got better recently. They did seem short staffed but all seems fine now". One relative

told us, "Yes there is enough staff, they are always very attentive". Staff told us they felt there was enough staff on duty. One member of staff said, "We have been short staffed but it is improving. Staffing levels have increased. You always wish there was more staff but we do manage on the staffing levels we have now."

During the inspection we looked at four staff recruitment files. We could see from the records we looked at that safe recruitment procedures were followed. Applications and interviews had been completed. Two checked references and a Disclosure and Barring Service (DBS) check had been sought prior to staff starting employment at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people working with vulnerable adults.

Communal areas and bathrooms were clean and tidy. Cleaning equipment was securely stored when not in use in a locked room. Throughout the day we saw housekeeping staff cleaning communal areas, bathrooms and people's rooms.

Good

Is the service effective?

Our findings

We asked staff to tell us about their induction, training and development opportunities they had been given at the service. Staff told us, "We have done more training recently and I know there is a lot of training planned over the next couple of months. I feel I have the training I need to do my job correctly." Another staff member told us, "I did an induction when I first started. It covered lots of things. Training is good, I quite enjoy it. I have done some recently." We spoke to the manager about training who told us that lots of training was planned in the next couple of months. We looked at a training plan which showed training was planned.

We looked at a training matrix which confirmed that some mandatory training for staff was not up to date. Mandatory training is training the registered provider thinks is necessary to support people safely. The manager told us that mandatory training was covered during the induction process and robust plans were in place to ensure all staff had completed all mandatory training within the next two months. A large amount of training had already been completed by staff since the training plans had been implemented by the manager and we could see that further training was planned throughout August and September 2016. We looked at four staff files to evidence training that had been completed. Certificates were not always available. For example, for one staff member it was recorded that they had received training in medication awareness in May 2016, but there was no certificate to evidence this. The manager told us this was due to the training provider not always providing certificates following training. The manager was able to show us emails that had been sent to the training provider requesting any missing certificates. Copies of certificates we identified that were 'missing' were sent to us following the inspection.

People we spoke with told us they thought staff were suitably trained to look after them. One person told us, "I have never had a problem. They all seem to know what they are doing."

Staff were supported with regular supervision and appraisal. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. From the records we looked at we could see that these meetings were used to discuss any support needs the staff member had, as well as confirming their knowledge and performance over a period of time. Records confirmed regular supervisions and appraisals were taking place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make particular decisions, any made on their behalf must be in their best interests and 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 Mental Capacity Act, and whether any conditions on authorisations to deprive a person of their liberty were being met.

One care plan that we looked at provided details of a best interests decision that had been made with regards to the covert administration of medication. We could see a GP had completed a best interest assessment and this was documented in the care plan. There was evidence of other professions and relatives being involved in the best interest decision. However, we saw one care plan for a person who had capacity, but a capacity assessment had been completed. There was no information in the care plan to suggest this person lacked capacity so it was not clear why this assessment had been completed.

Staff we spoke with had a good understanding of the Mental Capacity Act 2005 and were able to explain what action they would take if they suspected a person lacked capacity.

Staff had a good understanding with respect to people's choices and consent. We could see that consent to care had been given by people or, where appropriate, their relatives, and signed documentation was present in care plans to evidence this. These documents covered areas such as consent to treatment, sharing information, medication being administered and photographs being taken.

Some people who used the service had made advanced decisions on care and treatment and 'do not attempt cardio-pulmonary resuscitation' (DNACPR) were in place. These DNACPR documents had been completed by relevant professionals and were in date. The deputy manager told us they used a tracker so they could ensure DNACPR's were reviewed in a timely manner.

People were supported to maintain a balanced diet. People weights were monitored and recorded on a monthly basis. People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). People's weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health professionals if needed. Staff were able to tell us whether the people they supported had specific dietary needs and if so what they were. The cook was knowledgeable about peoples nutritional needs and preferences and was able to describe how the menu could be adapted to meet people's needs. These included adapting dishes to people's requirements (such as soft diets or diabetic diets) and ensuring alternatives were available if people did not want what was on the daily menu.

We looked at a menu plan. We could see there was a four weekly rolling menu. There were two meal options available at tea time and a selection of food available at lunch time including jacket potato with choice of fillings, soups, sandwiches and salads. There was also a daily 'chef special' which people could request.

We saw people were able to eat at flexible times. There was an allocated time for lunch and tea meals, but these could be changed to accommodate people's wishes. Refreshments and snacks were provided throughout the day. People told us they enjoyed the food at the service. One person told us, "The food is good and always nicely presented."

We observed the lunch time routine. The tables were pleasantly presented and condiments were available. People were helped to sit comfortably in a seat of their choice. We saw one person who insisted on moving seats and tables several times. Staff accommodated the persons wishes and offered assistance where needed. There was enough staff on duty to assist people and consent was obtained before staff assisted with feeding. We could see that people were relaxed in the environment and laughter and singing could be heard coming from the dining room.

Care records contained evidence of close working relationships with other professionals to maintain and promote people's health. These included GP's, district nurses, social workers and dieticians. We could see

that referrals to these professionals had been made in a timely manner and these visits were recorded in people's care records.

The service was clean and neutrally decorated throughout. However, the building was not adapted to support people living with a dementia. For example, doors and handrails were not colour-coded or marked in a way that would help people living with a dementia recognise them. Communal areas lacked décor which would help a person living with a dementia navigate to their room or help them recognise certain facilities such as bathrooms and toilets. We spoke to the manage about this who told us that they wanted to redecorate the service to make it more 'dementia friendly' which included putting people's photographs on their bedroom doors.

Good

Is the service caring?

Our findings

People who used the service told us they were very happy and staff were caring. One person said, "I don't find any staff rude or aggressive or anything like that" and "I am so well looked after here." Another person told us, "Yes they are (caring) and they have the patience of saints."

During the inspection, we spent time observing staff and people who used the service. On the first day of inspection, we saw one person assisted the activities coordinator who was preparing for a summer fayre. The person clearly enjoyed helping with the planning of this event and this was encouraged by the activities coordinator who gave clear instruction on tasks that needed to be completed. We also saw staff spending time with people, chatting about general topics and sharing jokes as they moved around the building. This helped to create a relaxed and homely atmosphere throughout the service.

We saw staff were respectful and called people by their preferred names. Staff were patient with people when speaking to them and took time to ensure people understood what was being said. Staff members often approached people who used the service to check they were ok and had general conversations about the person's day and what their plans were for the coming week.

Staff explained to us how they respected a person's privacy and dignity, by keeping curtains and doors closed when assisting people with personal care and by respecting people's choices and decisions. We saw staff seeking permission before any care and treatment was provided to people and people we spoke with confirmed this. One person said, "I can go to my room when I wish and staff always knock before entering. They always ask me before they do anything, even if it's just to move a remote or something simple like that. They make sure people know what they are doing." We observed staff discreetly seeking permission from one person to assist them to the toilet. The staff member asked the person if they would like assistance to get to the toilet and only when permission was given did they assist.

Care plans detailed people's wishes and preferences around the care and treatment that was provided. We could see evidence, such as signatures in care plans, that people were being involved in care planning and, in some situations, relatives had also been involved. Relatives we spoke with confirmed they were involved in their relatives care needs. One relative told us, "They do tell me if anything has changed or if they have any concerns."

People spent their recreational times as they wanted to and had access to communal areas as well as private space if they wished. We saw people were able to go to their rooms, as they wished, throughout the day. People chose when they wished to rise on a morning and retire on an evening and people we spoke with confirmed this. This helped ensure people received care and support in the way that they wanted.

It was evident from discussions with staff and the deputy manager that all staff knew people well, including their personal history, preferences and like and dislikes. One staff member said, "These people are like family to me, I like to think I know them all inside out." The deputy manager told us, "I love to put on a uniform and work on the floor. I have been here years and I know all the people. I love to spend time with

them."

People who used the service had access to independent advocates. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. The deputy manager told us that people had used advocates in the past and information was available and displayed in the reception area of the service. Staff were aware of the process and action to take should an advocate be needed.

At the time of this inspection, there was no one receiving end of life care, however, information on people's wishes and preferences was documented in their care files.

Good

Is the service responsive?

Our findings

During our inspection we looked at four care plans. Care plans began with a pre-admissions assessment, which had been completed before the person moved to the service. This meant the service was ensuring they could meet people's care needs before they moved to the service and looked at areas including medical history, mobility, skin condition and communication needs. A 'useful information to care for me' documented had also been completed. This contained details such as name, previous address, birthday, family and friends, regular visitors, likes and dislikes and places of interest.

Care plans were produced to meet individual's supports needs in areas such as communication, mobility, nutrition, personal hygiene and sociability. Care plans were detailed and focused on the person's preferences and were reviewed on a monthly basis. The care plans that we looked at were all up to date and were person centred. For example, one care plan detailed that the person was able to communicate, but required staff to ensure they were face to face to the person so they could lip read. Another care plan detailed that support with oral hygiene was needed. This gave full details about how this was to be provided and how often this support was needed. Another care plans detailed that a person liked to have a moustache, but otherwise liked to be clean shaven.

When people had a specific care need plans were in place to help ensure they received person-centred support. For example, one person was assessed as high risk of falls. A mobility care plan had been developed to help manage this and a monthly analysis of falls had also been completed.

We spoke with staff who were extremely knowledgeable about the care that people received. Staff were responsive to the needs of people who used the service and people and relatives that we spoke with confirmed this. One person told us, "They [staff] are all great. I don't know what I would do without them. They know me inside out." A relative we spoke with said, "They know [relative] as well as I do and they have wonderful relationships."

People were supported to access activities which they enjoyed. The service employed an activities coordinator who planned activities according to the preferences of people who used the service. Board games, reading material and movies were available throughout the service and we saw people enjoying watching television in the communal lounge.

On the day of inspection, we saw little evidence of planned activities taking place. We spoke with the manager about this who told us the activities coordinator had been extremely busy planning the services' summer fayre, which was due to take place in the next couple of days and that people had been assisting the activities coordinator in preparation for the fayre. Throughout the home we saw photographs of activities that had taken place such as sing-a-longs with outside entertainers, concerts arranged by local schools and visits from a local pet therapy group.

We spoke with the activities coordinator who told us a weekly timetable was arranged with a variety of activities including bingo, walks in the community, visits to a local church café, crafts, movie afternoons and

a variety of entertainers that visited the service on a regular basis. People who were living with a dementia were also supported to visit the local library for dementia friendly activities. Reminiscence boxes had also been developed by the activities coordinator and staff. However, records lacked details as to what activities people had participated in. It was not clear from records if people were actively involved in activities or if people had enjoyed the activities on offer.

We asked people who used the service about activities on offer. People told us, "There is always something to do" and that staff "Keep them busy."

We were given a copy of the registered provider's complaints procedure. The procedure gave people details about who to contact should they wish to make a complaint and timescales for actions. The deputy manager told us that both them, and the manager, spoke with people on a daily basis so people who used the service would generally express any concerns they had to them and this was encouraged by management. One person told us, "I would speak to [deputy manager] if I had any problems. To be honest I could speak to any of the staff. I can't say I have any complaints at the moment." Another person told us, "I don't need to complain, I am happy here."

We looked at the record of complaints. Two complaints had been received in the past 12 months, concerning a fall a person suffered and the quality of food at the service. These had been investigated in line with the complaints policy and outcomes sent to all parties involved.

Good

Is the service well-led?

Our findings

The manager joined the service in February 2016 and was in the process of applying to be registered manager. The manager had a clear vision of the culture of the service and told us, "There are improvements to be made but we are making steady progress in the right direction and the staff are all very supportive of the changes. Staff can see these changes are for the better."

People who used the service spoke positively about the manager. We could see the manager had a visible presence at the service and regularly interacted with people. There was a management office located on the ground floor of the service and throughout the day of inspection we saw people coming into the office to speak to management. The deputy manager spent a lot of time with people who used the service and staff, having conversations with people about their health, any plans they had for the coming week and observing practice around the service. One person told us, "Oh [deputy manager] is lovely, and the manager. Things have got better since they came." It was clear that the manager was familiar with people who used the service and relatives that came to visit. During the inspection one relative approached the manager to ask for assistance with a call bell. The manager responded immediately and took remedial action to ensure the issue was resolved.

We asked staff about the management of the service. All staff we spoke with confirmed they were supported by management and the changes they had implemented, such as increasing staffing levels. One person told us, "We used to have a problem with staffing but [manager] has sorted that now. We all discussed it and extra staff are now on each shift. We are more included now as well." Another staff member told us, "The new manager hasn't been here that long but I can already see an improvement. [Manager] is approachable and asks the staff what we think which is something that had never happened before." Staff told us the moral was improving at the service.

Regular staff meetings had taken place with the most recent meeting in July 2016. The minutes of the meeting showed that staff had the opportunity to raise concerns and be involved in decisions about the service. Areas that were discussed included annual leave, infection control, safeguarding and activities. Regular resident meetings had also taken place. People were given the opportunity to discuss areas such as menu plan and activities.

During the inspection, we looked at feedback that was sought from staff and people who used the service. Questionnaires had been distributed, but very few had been returned. We spoke with the manager about this who told us that all questionnaires should be returned by the end of August 2016. Following this date, the questionnaires would be analysed and action plans developed where needed. The manager told us the information would also be displayed in the service to keep people informed of any action they planned to take. A suggestions box was also displayed in the main reception area so people who used the service, staff, relatives and other professionals could make comments or suggestions about the service. This box was checked every week by the deputy manager.

The manager carried out a number of quality assurance checks to monitor and improve standards at the

service. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services, ensuring they provide people with good services and meet the appropriate quality standards and legal obligations. Monthly audits were carried out in areas such as health and safety, infection control, nutrition, medication, care plans and catering. From the records we looked at, we could see where issues had been identified, action plans had been developed to ensure remedial action was taken. For example, a care plan audit identified that information was missing from a moving and handling document. An action plan for the care plan to be amended was put in place. Training was not up to date for all staff, however, plans had been put in place by the manager to correct this.

From discussions with the manager, we could see that continuous improvements were being made and people who used the service were at the centre of this.

The manager understood their roles and responsibilities and was able to describe the notification they were required to make to CQC.