Z.A.K. Healthcare Limited

Queens 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

The inspection took place on 12 and 14 July 2016 and was unannounced on the first day. At the last inspection, in August 2014, the service was judged compliant with the regulations inspected.

The service has a registered manager who had been registered with the Care Quality Commission since August 2014. 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.

Queens Care Centre is a purpose built home with accommodation situated on three floors. The home accommodates up to 67 people that requires personal care. It is situated on the outskirts of Rotherham in the village of Maltby and is close to local shops and amenities.

The requirements of the Mental Capacity Act 2005 were in place to protect people who may not have the capacity to make decisions for themselves. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment.

People's physical health was monitored as required. This included the monitoring of people's health conditions and symptoms so appropriate referrals to health professionals could be made. We spoke with a visiting community nurse who said, "The staff acted in a timely manner to seek my advice. I think the home is well led and the care is person centred. All referrals made by the staff are appropriate." The nurse told us that they had received a referral for a person who had been identified as a falls risk.

People were protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were in place for the recording, safe keeping and safe administration of medicines. Protocols were in place for administering 'as required' medication for pain. Some protocols that we identified as missing on the first day of the inspection had been added when we returned to complete the inspection.

There were sufficient staff with the right skills and competencies to meet the assessed needs of people living in the home. Staff were aware of people's nutritional needs and made sure they supported people to have a healthy diet, with choices of a good variety of food and drink. People we spoke with told us they enjoyed the meals and there was always something on the menu they liked. We observed the mealtime experience on both days of this inspection and found improvements could be made.

The environment was clean and tidy. However some carpets in communal areas and corridors were showing wear and tear. The registered manager told us these areas were on the refurbishment programme to be

replaced. Some areas of the home were decorated in a dementia friendly way. However, we found signage could be improved in communal areas. Dining areas required attention to make them more dementia friendly. For example display boards for menus and the date and seasons would help people living well with dementia orientate to time and place.

People were able to access activities. The activity coordinators had developed a weekly plan of activities. People could also access religious services which were held periodically at the home. We saw some of the activities available to people during the inspection. For example, flower arrangements, bingo, hairdressing and one to one pampering.

We found the service had a friendly relaxed atmosphere which felt homely. Staff approached people in a kind and caring way which encouraged people to express how and when they needed support. Everyone we spoke with told us that they felt that the staff knew them and their likes and dislikes. One person said, "I like it here the staff are kind and friendly." Relatives also confirmed to us that they thought the staff supported people appropriately and encouraged people to be involved in their care.

Staff told us they felt supported and they could raise any concerns with the registered manager and felt that they were listened to. People told us they were aware of the complaints procedure and said staff would assist them if they needed to use it. We saw a number of complaints had been appropriately investigated in a timely manner.

There were effective systems in place to monitor and improve the quality of the service provided. We saw copies of reports produced by the registered manager and the provider. The reports included any actions required and these were checked each month to determine progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the homes procedures in place to safeguard vulnerable people from abuse.

People's health was monitored and reviewed as required. This included appropriate referrals to health professionals. Individual risks had also been assessed and identified as part of the support and care planning process.

There were enough qualified, skilled and experienced staff to meet people's needs. We saw when people needed support or assistance from staff there was always a member of staff available to give this support.

Medicines were stored and administered safely. Staff and people that used the service were aware of what medicines were to be taken and when.

Is the service effective?

Good

The service was effective.

Each member of staff had a programme of training and were trained to care and support people who used the service safely, to a good standard.

The staff we spoke with during our inspection understood the importance of the Mental Capacity Act in protecting people and the importance of involving people in making decisions. We also found the service to be meeting the requirements of the Deprivation of Liberty Safeguards.

People's nutritional needs were met. The food we saw, provided variety and choice and ensured a well-balanced diet for people living in the home. We observed people being given choices of what to eat and what time to eat.

Is the service caring?

Good

The service was caring.

Staff had a good approach to their work. People told us that staff were very caring and respected their privacy and dignity.

Staff were motivated and passionate about the care they provided. They spoke with pride about the service and the focus on promoting people's wellbeing.

People were supported to maintain important relationships. Relatives told us there were no restrictions in place when visiting the service and they were always made to feel welcome.

The service had a strong commitment to supporting people and their relatives to manage end of life care in a compassionate way.

Is the service responsive?

Good

The service was responsive.

People had their care and support needs kept under review. Staff responded quickly when people's needs changed, which ensured their individual needs were met.

People had access to activities that were important to them. These were designed to meet people's individual needs, hobbies and interests, which promoted their wellbeing.

People's concerns and complaints were investigated, responded to promptly and used to improve the quality of the service.

Is the service well-led?

Good

The service was well led.

The registered manager had developed a strong and visible person centred culture in the service. Staff were fully supportive of the aims and vision of the service.

There was a strong emphasis on promoting and sustaining the improvements already made at the service. Staff told us that the management team were knowledgeable which gave them confidence in the staff team and led by example.

The registered manager continually strived to improve the service and their own practice. Systems were in place for recording and managing complaints, safeguarding concerns and incidents and accidents. Documentation showed that

management took steps to learn from such events and put measures in place which meant they were less likely to happen again.

Queens 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 was 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 12 and 14 July 2016 and was unannounced on the first day. The inspection team consisted of two adult social care inspectors. At the time of our inspection there were 60 people using the service. We spoke with the registered manager, the deputy manager and a senior carer. We also spoke with three senior carers, seven care staff, the activity coordinator and the cook. We spoke with 15 people who used the service and 11 visiting relatives. This helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

We spent time observing care throughout the service. We also 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.

Prior to the inspection we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We spoke with the local council quality assurance officer who also undertakes periodic visits to the home. They told us they had confidence in the registered manager to lead the staff at the service. We spoke with a community nurse and a social worker and two physio-therapists who were undertaking a review of a people's care packages. They spoke highly of the staff and how the home was managed.

Before our inspection we reviewed all the information we held about the service. The provider had completed a provider information return (PIR). This is a document 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 looked at documentation relating to people who used the service, staff and the management of the service. We looked at seven people's written records, including the plans of their care. We also looked at the systems used to manage people's medication, including the storage and records kept. We looked at the

quality assurance systems to check if they were robust and identified areas for improvement.

Good

Is the service safe?

Our findings

We asked if people felt safe in the home and they said that they did. For instance, one person said, "I feel very safe." Another person said, "They [staff] look after us very well, I have no problems. If there was a problem the staff would deal with it for me." A relative we spoke with said, "The home is very well run so I have no worries about the safety of my [family member]."

Care and support was delivered in a way that promoted people's safety and welfare. Care files checked showed records were in place to monitor any specific areas where people were more at risk, and explained what action staff needed to take to protect them. For example the risks associated with falls were managed by making referrals to the falls team when required. Staff also obtained equipment such as falls mats to alert staff if the person got up out of bed in order to reduce the risk of the person falling. Each person also had a personal evacuation plan in case of fire. The registered manager told us that these were easily accessible if required in the event of an emergency. We saw systems were in place for events such as a fire and regular checks were undertaken to ensure staff and people who used the service understood those arrangements.

We observed staff helping people to move around the home, with and without the use of aids. In each case they assisted people in a safe way. The relatives we spoke with felt the home was a safe place for their family member to live. One person commented, "The bedrooms are spacious so there are no obstacles she can trip over."

A safeguarding adult's policy was available and staff were required to read it as part of their induction. We spoke with staff about their understanding of protecting adults from abuse. They told us they had undertaken safeguarding training and would know what to do if they witnessed bad practice or other incidents that they felt should be reported.

Staff were aware of the local authorities safeguarding policies and procedures and would refer to them for guidance if needed. They said they would report anything straight away to the senior carer or the registered manager. Staff had a good understanding about the services whistle blowing procedures and felt that their identity would be kept safe when using the procedures. We saw staff had received training in this subject.

Overall the people we spoke with felt there was enough staff available to meet the needs of the people currently living at home. One person told us, "There always seems to be enough staff on duty. If I need a carer I can always find one within a few minutes." However three relatives said they thought additional staff would be beneficial at key times, such as mealtimes. One person also commented about staff not always being available in lounges, which worried them as they said people tended to get up and were unsteady on their feet, so may fall. Another relative said that on occasions if two people needed assistance to go to the toilet at the same time, one would have to wait if two staff were required to assist one, or both of them.

At mealtimes on the ground floor most people ate independently so did not require assistance from staff. However, we saw one person struggling to eat their meal with a knife and fork, but assistance was not readily available as staff were serving meals to other people and collecting used crockery.

We found the recruitment of staff was robust and thorough. Application forms had been completed, two written references had been obtained and formal interviews arranged. All new staff completed a full induction programme that, when completed, was signed off by their line manager.
The registered manager told us that staff were not allowed to commence employment until a Disclosure and Barring Service (DBS) check had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helped to ensure only suitable people were employed by this service. The providers were fully aware of their accountability if a member of staff was not performing appropriately.

A new member of staff confirmed they had undertaken a robust recruitment process which included a DBS check as well as the provider requesting two written references. They said all checks had been completed prior to them starting work.

A member of staff described how they had undertaken a structured induction to the home which included shadowing a senior member of staff for three days, completing an induction booklet and learning about the people who lived at the home as well as the company policies.

We looked at the number of staff that were on duty and checked the staff rosters to confirm the number were correct. The registered manager told us they used a dependency tool to assist with the calculation of staff needed to deliver care safely to people. The registered manager told us that the organisation calculates staffing ratios but she had flexibility to increase hours if required. We asked staff about the levels working during the day. They told us they were busy but had time to speak to people who used the service From our observations during the inspection we found staff were able to spend a limited amount of time with individuals, and we found the interactions when they did take place to be positive and meaningful.

The service had a medication policy which outlined how medicines should be safely managed. The registered manager told us senior care workers were responsible for administering medicines on the different units. During our inspection we observed staff administering medication to people living on the ground and first floors. They did this in a safe way that reflected good practice guidance, such as signing for medicines only when they had been taken by the person. One of the senior care workers described the system for ordering and managing medicines going in and out of the home. This included a safe way of disposing of medication refused or no longer needed. We checked if the system had been followed correctly and found it had.

We checked four people's medication administration record [MAR] which generally had been appropriately completed. However, two gaps were found on one of the MAR we sampled. The senior care worker told us the medicine had not been given as the person did not require it at that time. However, the MAR had not been completed with the appropriate code and reason as to why the medicine had been omitted.

Where controlled drugs were in use we saw there was specific storage available which met legal guidance. The service also had a controlled drugs register which provided the details for each person receiving a controlled medicine. We checked the four controlled drugs in the cabinet and found they tallied with the entries in the register.

When people were prescribed medicines 'to be given when required' [PRN] some people had protocols in place to tell staff what the medicine was for, and when and how to give it. For example, when paracetamol was prescribed for specific pain relief. However, on the first day of our inspection we found that although the files we checked had a medication care plan, not everyone had a protocol in place for PRN medicines. We discussed this with the registered manager who said they would address the shortfall as soon as possible.

When we returned to the home to conclude the inspection, the registered manager said all files had been checked, and where required all but 10 now had a PRN protocol in place. She said the remaining protocols would be completed as soon as possible. The protocols we sampled provided the correct information.

Where people required covert medication [this is when essential medicines are hidden in people's food or drink] meetings had been held and recorded to show this was in the person's best interest. The senior care worker described in detail how the medicine was administered to one person living at the home, but this information had not been comprehensively recorded in the person's care plan. Therefore there was no detailed information available to inform staff how best to administer this medication.

We saw where people were able to be responsible for their own medication this was encouraged. The deputy manager described how an assessment would be undertaken to make sure the person was able to undertake this task safely and this would be monitored by staff. Where people were taking responsibility for administering their own medicines we saw this was being done safely.

There was a system in place to make sure staff had followed the home's medication procedure. For example, we saw regular checks had been carried out to make sure that medicines were given and recorded correctly, and remaining medication tallied with the stock held. We also saw the dispensing pharmacy periodically audited the medication system in place and at their last visit they found no concerns. The audits on medication showed that where errors had occurred they were picked up and resolved immediately.

The temperature of room where medication was stored on the ground floor had been checked and recorded regularly, but this was not the case on the other two floors. We spoke with the registered manager about this. On the second day we visited the home they told us these checks had been put in place.

Senior staff who were responsible for administering medication had received training to update their knowledge and skills. We also found periodic competency checks were carried out to make sure staff were working to expected standards.

We checked around the home to see if it was clean and tidy. There were no obvious trip hazards and everywhere was very clean. We did not notice any unpleasant odours or badly stained furniture and bedding. We saw staff followed good hand hygiene procedures and protective equipment such as aprons and gloves were available throughout the building.

Good

Is the service effective?

Our findings

People were supported to have their assessed needs, preferences and choices met by staff that had the right skills and competencies. People who used the service and relatives we spoke with told us they thought the care staff were competent and well trained to meet their or their family member's individual needs to a good standard. One relative told us, "The staff are brilliant. There is good one to one [support] and they tend to all their needs." Another relative commented, "The staff are very good."

We joined a group of people eating their meals. We carried out a SOFI during lunch on the first day of this inspection. We observed lunch being served on four of the units. We saw some people chose to eat in the dining room, while others preferred to have their meal in the lounge area or in their own room.

The dining rooms on the ground floor had a relaxed atmosphere with appropriate music playing softly in the background. We saw tables were nicely set with tablecloths, serviettes, cutlery, flowers and condiments, and people were offered protection for their clothes on an individual basis. In the upstairs dining area people were needed more support and we found the service was a little chaotic. When we returned on the second day we found staff supported people appropriately, however this could still be improved further. For example, there was no visible signage regarding the menu choice. Plate guards were not used so some people pushed their meal either onto the table or the floor. The senior carer told us that guards had been tried but this was not very successful.

People told us staff asked them each day what meal they preferred, we saw the staff used this information when serving the lunchtime meals. Although a relative told us the days menu was normally written on a board outside the dining room this was not the case on the days we were there. The registered manager said this should have been on display. When we asked about providing a more dementia friendly way of telling people about the choices available, she said they were working on a picture format, which would be introduced shortly. In the meantime she said staff would use their knowledge of the person's preferences or showed them both options and let them choose.

The cook and kitchen assistant served the food onto plates, while care workers served the food to people and assisted some people to cut up their meal. The people we spoke with said they had enjoyed the lunchtime meal and were complimentary about the meals in general. One person told us, "The food is always lovely here." Another person using the service said, "There are always at least two choices [main courses]." A relative told us they visited the home twice a week to eat with their family member. They described the meals as, "Nice" adding, "The meal today was lovely especially the chicken and the homemade coleslaw." Another relative told us, "It always looks nice [the food]. Mum has always been complimentary about the meals. Staff helped her eat now and always offer encouragement and choice."

Meals served in the Queen Elizabeth unit were plated up at the servery on the Queen Mary unit. We saw these were put on a trolley to be taken the short distance to the other dining room but staff filled the top of the trolley before putting covers over the meals to protect them and keep them warm. This also raised the question of how people eating in that dining room would be offered second helpings, or given the

opportunity to change their minds about the meal the preferred. When we discussed this with the registered manager she said a hot trolley had been requested.

People's care records highlighted any special diets or nutritional needs people required and we saw this information had also been shared with the kitchen staff. Staff ensured people received the diets they needed, but on the first day we observed no-one was asked if they wanted a second helping of the main or pudding course. We also noted that a few people struggled to eat their meal. For example, they could not pick up food such as peas with their fork, however no plate guards were in use to assist them, and staff did not always provide prompt assistance where needed. One person living at the home said they had tried to use adapted cutlery, but they still could not always manage to hold them properly. They said they therefore tried to choose the best option from the menu, such as sandwiches at teatime, so they could manage without staff assistance.

We saw people had accessed healthcare professionals such as GPs, dieticians and physiotherapist when additional support was required. People who were at risk of poor nutrition or dehydration had a nutritional screening tool in place which indicated the level of risk and care plans told staff how this would be managed. We also saw records had been maintained to monitor people's food and fluid intake, as well as their weight. However, we noted that these forms had not been evaluated each day to make sure people were eating and drinking the right amount and therefore enable them to take prompt action to address and concerns. The registered manager said this would be addressed straight away. She later confirmed she had met with the night manager and asked them to ensure each form was evaluated.

We spoke with two visiting professional who told us staff were always welcoming and helpful. One said, "Staff greet us, check who we are and who we are visiting, then show us round to their room. They always request an update about what we have done and any changes." One of the professionals who had not visited the home before commented, "We go to quite a few care homes and this was a very pleasant experience."

The cook told us they received training specific to their role including food safety, healthy eating and food processing. They had a good knowledge of specialist diets. The cook had knowledge about the latest guidance from the 'Food standards agency.' This was in relation to the 14 allergens. The Food Information Regulation, which came into force in December 2014, introduces a requirement that food businesses must provide information about the allergenic ingredients used in any food they provide. The cook told us they had been awarded a 'five star' rating by the local council who were responsible for monitoring the food and cleaning standards. This represents the highest standard that can be achieved.

We looked at the care records for four people who used the service and there was evidence that people were consulted about how they wanted to receive their care. Consent was gained for things related to their care. For example we saw people had consented to the use of photographs on care plans and medical records. People were also consulted about their continuing involvement in care plan reviews. We saw care records were evaluated monthly.

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 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. Staff were aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own. At the time of the inspection the registered manager told us there were a number of people who had a DoLS authorisation and they had also made several applications to the local council's supervisory body. We looked at the care plans for the two people who were subject to DoLS and found appropriate measures had been taken to ensure people's care was given in the least restrictive way. The remaining applications which had been submitted were still awaiting decisions.

The staff we spoke with about their understanding of MCA. They were clear that the training they had received gave then a good understanding of promoting people's rights and choices. We saw that when people did not have the capacity to consent, procedures were followed to make sure decisions that were made on their behalf were in their best interests. The deputy manager told us that she was also the dementia lead for the home and had attended a nationally recognised course in dementia care. The training had given her the skills and competencies to lead staff in providing good dementia care.

Records we looked at confirmed staff were trained to a good standard. The registered manager and her staff had obtained nationally recognised care certificates. The registered manager told us all staff would complete a comprehensive induction which included, care principles, service specific training such as, equality and diversity, expectations of the service and how to deal with accidents and emergencies. Staff were expected to work alongside more experienced staff until they were deemed to be competent.

The registered manager was aware that all new staff employed would be registered to complete the 'Care Certificate' which replaced the 'Common Induction Standards' in April 2015. The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

A senior care worker told us they felt they had received all the training they needed to carry out their job. They said this included all the companies mandatory training, as well as further training such as distance learning courses. They described the company trainer as "Great" saying they made the sessions enjoyable and interesting. Courses completed included: medication, team leading, equality and diversity, first aid, managing challenging behaviour and hand hygiene.

Systems to support and develop staff were in place through regular supervision meetings with the registered manager. These meetings gave staff the opportunity to discuss their own personal and professional development as well as any concerns they may have. A senior care worker said they received regular supervision sessions, which they found useful.

Good

Is the service caring?

Our findings

People told us they were happy with the care and support they received. We saw staff had a warm rapport with the people they cared for. People were treated with respect and their dignity was maintained throughout. We observed numerous kind and caring interactions throughout the day. Staff and people who used the service clearly have a good rapport. It was very clear that staff knew people well and were able to tell us about individual people and their life histories. People's needs and preferences were recorded in their care files.

We observed staff supported people in a caring and responsive manner while assisting them to go about their daily lives and take part in social activities. Throughout our inspection staff interacting positively with people who used the service. They gave each person appropriate care and respect while taking into account what they wanted. We saw staff enabled them to be as independent as possible while providing support and assistance where required.

The relatives we spoke with said their family member was given choice about where and how they spent their time, as well as the meals they wanted and what activities they preferred to join in. We saw people getting up at different times, with some people choosing to eat their breakfast in their bedroom before getting dressed. Other people said they preferred to get dressed and eat in the dining room, which staff respected.

The people we spoke with described the staff as caring and responsive to people's needs. One relative described the staff as "Caring and capable" which they said gave them reassurance.

We saw people's rooms were personalised to meet their needs and preferences. This included family photos, mementos and small items of furniture. However, in one room used by someone on a short stay basis we noted there was no coffee table for them to put their drink. Their relative had turned a drawer on its side to provide somewhere for them to put their cup of tea.

The service had a stable staff team, the majority of whom had worked at the service for a long time and knew the needs of the people well. The continuity of staff had led to people developing meaningful relationships with staff. Staff showed empathy when trying to talk to a person that seemed distressed when asking when they could go home. Staff spoke quietly to the person and made them feel more at ease; they reinforced the fact that they were living at the Queens Care Centre and that their family would be visiting later in the day.

People told us that staff were caring and respected their privacy and dignity. Our observation during the inspection confirmed this; staff were respectful when talking with people calling them by their preferred names. We observed staff knocking on people's doors and waiting before entering. Staff were also observed speaking with people discretely about their personal care needs. A relative told us, "I am happy with all the care my mum has. She is fairly self-sufficient." Another relative commented, "From what I see staff are caring and respect people's dignity" and "She goes to the hairdresser every week, always has a nice dress on and

looks clean and tidy."

People living at the home told us, "The staff listen to you and ask about things, such as if I prefer a male or female carer. I told them [staff] I don't mind" and "I like staying in my room, but staff come in and check on me and I have my alarm bell [which was pinned to the chair for easy access]."

Relatives told us staff were good at keeping them informed of changes in their family member's condition. One person said, "The staff always call me, even at night [which they said was their choice]. For example, they called me when she needed to go into hospital. They asked if I wanted to go with her or if staff should go, it felt good to be involved."

The service had a strong commitment to supporting people and their relatives, before and after death. Some people had end of life care plans in place, we saw that next of kin and significant others had been involved as appropriate. These plans clearly stated how they wanted to be supported during the end stages of their life. Do Not Attempt Resuscitation (DNAR) forms were included and were reviewed as and when required by the person's doctor. The registered manager told us that they worked closely with the local Hospice and McMillan nurses to ensure people received the best care possible as they approached the later stages of life. The registered manager showed us thank you cards from the relatives of people who had passed away. They were all very complimentary of the care provided.

Good

Is the service responsive?

Our findings

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The people we spoke with told us the standard of care they received was good. We looked at copies of seven people's assessments and care plans. They gave a clear picture of people's needs. Most were person-centred in the way that they were written. For example, they included such information as people's preferences about their likes and dislikes in relation to food and leisure activities, and the times they usually liked to go to bed and to get up. Some care plans did required more detail and we discussed this with the registered manager.

Relatives, and the people we spoke with who used the service, confirmed they had been involved in planning and reviewing care plans. One relative described how the registered manager had assessed their family member prior to them being admitted to the home. Another relative said, "The senior carer and the manager ask if everything is okay. About three to four weeks ago we [themselves and the senior care worker] sat down and went through the care plan. They pointed out any changes and then I signed and dated them. They also outlined how specialist equipment had been arranged to meet their family member's needs, such as a profiling bed with bedsides, which they said "It was done to protect her."

Daily handovers ensured new information was passed at the start of each shift. This meant staff knew how people were presenting each day. We saw completed daily bulletins which gave important information to staff.

The registered manager told us that they employed three staff who were activity coordinators. We spoke with one of the coordinators who showed us the activity plan which set out activities for a period of three weeks. During the inspection we saw people taking part in a game of bingo and a flower arranging session. People said they enjoyed the activities provided. A relative told us their family member enjoyed bingo, flower arranging and the outside entertainers that visited the home each month. However, they thought there should be trips out into the community and to places of interest.

One person told us, "I like to sit in my room. There are plenty of activities, but I can't do some of them [due to a medical condition]. They showed us a copy of the weekly activity plans, which they said were given to people living at the home so they knew what was available.

We spoke to a community health worker who was visiting the home and she told us, "It's really good here. We don't get any inappropriate referrals and the staff are on the ball. They [staff] will phone for advice if they need it. They told us they were visiting people who used the service that had been referred by the home because of falls occurring.

All the relatives we spoke with told us that the home is welcoming and that there were no restrictions on visiting. One relative told us, "I can come whenever I want. I come at lunchtime so that I can have a meal with my family member."

The registered manager told us there was a comprehensive complaints' policy and procedure, this was explained to everyone who received a service. It was written in plain English and we saw these were displayed on the notice board in the entrance. The registered manager told us that they met regularly with staff and people who used the service to learn from any concerns raised to ensure they delivered a good quality service. The people we spoke with said they had not raised any complaints but knew who to speak with if any concerns arose.

One person we spoke with told us about some money going missing from their family member's purse. We discussed this with the registered manager. Although this had been reported to the senior care worker and the deputy it had not been recorded or passed on to the registered manager. They immediately spoke with the relative to try to address the situation.

Good

Is the service well-led?

Our findings

The service was well led by a manager who has been registered with the Care Quality Commission at this location since September 2014. She was appointed into the post in July 2013.

People we spoke with were very complimentary about the registered manager. They said she was approachable and always willing to listen to them and act on anything they spoke to her about. One relative told us, "She [the registered manager] is visible, understanding, responsive and approachable. She will sit and talk to me on my level, not talk down to me. She listens. When you go in to see her she blocks everything else out while she is talking to you giving you her full attention."

When we asked the people if there was anything they felt could be improved most people could not think of anything. One person told us, "There is nothing they could do to make her [person using the service] more comfortable or improve the quality of her life." However, some people mentioned areas they felt could be better. This included having staff visible in communal areas, more trips out to places of interest, and improving the signage to help people find their way around the home. One relative said they felt the home could be more dementia friendly. For example they said that in the Queen Elizabeth lounge there was nothing to remind people what the date and time was.

Staff told us that the registered manager and deputy manager were very knowledgeable and inspired confidence in the staff team, and led by example. They said that the service was well organised and that the management team were approachable, supportive and very much involved in the daily running of the service. Health professionals and the local council contract commissioners told us they thought the home was well organised and delivered good person centred care.

The registered manager told us they had developed a 'Facebook account' and we were shown examples of entries made by satisfied relatives. We saw evidence of consent being obtained from people who used the service before any pictures were posted on the site.

We looked at a number of documents which confirmed the provider managed risks to people who used the service. For example we looked at accidents and incidents which were analysed by the registered manager. She had responsibility for ensuring action was taken to reduce the risk of accidents/incidents re-occurring. We were told that they had identified trends of more frequent accidents occurring during the night which had led to more increased night checks being implemented. This had reduced the amount of accidents that occurred in subsequent months.

The registered manager continually sought feedback about the service through surveys, formal meetings, such as individual service reviews with relatives and other professional's, and joint resident and relative meetings. We saw that there had been high satisfaction levels from those that had responded to questionnaires. However, we did not see how the manager had communicated any actions that had been brought about for areas that scored less than the required level expected by the registered manager.

A number of audits or checks were completed on all aspects of the service provided. These included administration of medicines, health and safety, infection control, care plans and the environmental standards of the building. These audits and checks highlighted any improvements that needed to be made to improve the standard of care provided throughout the home. We saw evidence to show the improvements required were put into place immediately.