Barchester Healthcare Homes Limited

Southerndown

Inspection report

Worcester Road
Chipping Norton
Oxfordshire
OX7 5YF

Tel: 01608644129
Website: www.barchester.com

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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 inspected this service on 18 and 19 October 2016. Southerndown provides accommodation and nursing care for up to 87 older people. The service comprises of two separate units "Elderly Frail" general nursing unit and "Memory Lane" for people living with dementia. At the time of our visit 71 people were using the service.

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

At our last inspection in August 2015 we found people were not always protected from the risk of infection. Staff used the same body sling to assist two people with transfers and we found the sluice rooms on each floor of the home were not being kept clean. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had implemented the improvements required and all previous issues with regard to the infection control had been addressed.

People's risk assessments and support plans were detailed and contained clear information for staff. People's care records were reviewed every month or when the person's care needs had changed. Where people had pressure reliving mattresses in place, there was no recorded guidance in relation to settings required for an individual. There was no evidence that regular checks of the settings of mattresses took place to ensure these were set appropriately for people. This meant people could be at risk of developing pressure sores. The registered manager immediately organised for these to be reviewed and updated.

Accidents and incidents were recorded and investigated. The registered manager had a system to monitor the accidents to identify any trends or patterns. People received their medicines as prescribed and in line with the organisation's medicines policy. We observed that medicines were given to people in a professional and safe manner.

There were sufficient staff on duty to meet people's needs. People were assisted promptly and with no unnecessary delay. There was a safe recruitment system in place that helped the management ensure people were cared for by suitable staff. People were supported by staff that were knowledgeable about their responsibilities and had the relevant skills and experience. Staff told us they were well supported and records confirmed they received regular supervision sessions.

Staff demonstrated knowledge of principles and their responsibilities of the Mental Capacity Act 2005. Mental capacity assessments were completed where required and we saw the evidence on people's files. Where people were at risk of having their liberty deprived appropriate applications were sent to the local authority for authorisation.

People were supported to maintain a balanced and nutritious diet. People at risk of malnutrition had appropriate assessments and we saw the detailed records were kept of their food and fluid intake. People were supported to access a range of healthcare professionals and their input was incorporated into people's care plans. People's needs were assessed before they came to live at the service. People's care plans contained information about people's individual health and social care needs, their wishes and preferences.

People were cared for by staff that respected their privacy and dignity and promoted people's independence. Staff spoke about people in a warm and professional manner and they were enthusiastic about working at the service. People we spoke with told us they were happy with the care and complimented the staff.

People knew how to make complaints and provider had a complaints policy and procedure in place. The registered manager ensured when a complaint had been raised it had been investigated promptly and in a timely manner. People's feedback was obtained through satisfaction surveys and residents meetings we saw feedback was actioned as appropriate.

The staff and the registered manager promoted an open, honest and transparent culture. The registered manager provided strong leadership to the team, there was a clear staff structure and the staff knew their roles and responsibilities. The provider had effective systems in place to monitor the quality of the service. The audits included various aspect of service delivery. Any issues identified during audits were compiled into an ongoing action plan with clearly planned dates for completion.

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.

Risks to people's individual needs had been identified, assessed and recorded.

People's medicines were managed safely and people received their medicine as prescribed.

Staffing levels were sufficient to meet people's needs.

Staff knew what action to take if they had any concerns around suspected abuse.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the right skills and knowledge and had received appropriate training to carry out their roles.

People and their relatives, where appropriate, were involved in decisions about their care. Staff understood and followed the requirements of the Mental Capacity Act 2005.

People's nutritional needs were assessed and people were supported to maintain sufficient food and fluid intake.

People were supported to access health professionals when required.

Is the service caring?

Good

The service was caring.

People complimented the caring nature of staff.

People's privacy and dignity was respected.

Staff spoke about people in a professional, respectful and warm manner.

Staff were motivated and enthusiastic about caring for people.

Is the service responsive?

Good

The service was responsive.

People's care plans were up to date and regularly reviewed.

Staff were responsive to people's needs.

People were able to participate in activities of their choice.

People and their relatives knew how to raise concerns.

Is the service well-led?

Good

The service was well-led.

The registered manager used a range of effective audits to monitor the quality of service.

People were encouraged to give their views about the service and these were acted upon.

Staff worked well as a team and complimented the support from the management.

Southerndown

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 checked 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 18 and 19 October 2016 and was unannounced. The inspection team consisted of two inspectors, a nurse Specialist Advisor 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.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to tell us about. We asked the provider to complete a Provider Information Return (PIR). The provider had completed and submitted their PIR. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority commissioners of the service to obtain their views.

During our inspection we spent time observing care throughout the service. We spoke to nine people and three relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the registered manager, two registered nurses, five care staff, the chef and the activities co-ordinator. We also contacted three external professionals who had been involved with the people living at the service to obtain their views.

We looked at records, which included thirteen people's care records, a sample of the medication administration records and six staff recruitment files. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, staff training and support information, staff duty rotas and the arrangements for managing complaints and accidents.

Good

Is the service safe?

Our findings

At our last inspection in August 2015 we found people were not always protected from the risk of infection. Staff used the same body sling to assist two people with transfers and the sluice rooms on each floor of the home had not been kept clean. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager submitted an action plan explaining how these concerns were going to be addressed.

At this inspection we found the provider had implemented the improvements required and we found sluice rooms were refurbished and were kept tidy. All people requiring hoisting had their own personal slings that were labelled and stored in their bedrooms. Additionally, spare slings were available to be used in an emergency for people who normally did not need these.

People told us they felt safe living at the service. Comments included "Yes, I do feel safe", "I have no worries about how I'm treated", "I like it here, I feel safe" and "I do feel safe, it is nice here". A person's relative also commented "Yes, [person] is safe". Staff were aware of safeguarding issues and their responsibility to report any concerns. Staff knew to access the safeguarding policy for guidance. Staff we spoke with told us they would not hesitate to report if they witnessed any suspected abuse. One member of staff told us, "I've done all the training. I'd report to the head nurse or team leader and local authorities if I had any concerns". Another one said, "I'd tell the nurse on duty or call safeguarding".

There was sufficient staff on duty to meet people's needs. The registered manager used a dependency tool to assess the staffing levels required. Staff told us they felt there was enough staff. Comments included, "There is enough staff, every day is different and some days residents can be a bit more needy but generally there is more than enough staff" and "Sometimes a bit tight with sickness or leave but mostly it is fine". One person said, "If I need any help I can just ask, there's always someone around". One person's relative commented positively on continuity of staff. They said, "Staff seem to understand people's needs, several staff have been here a long time, it seems a very happy unit". Throughout our inspection we observed the call bells were answered promptly.

The registered manager ensured a safe recruitment and selection process was followed. Staff files contained the required pre-employment checks. This included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. The professional qualifications of nursing staff had also been checked to ensure they were fit to work.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage these risks. For example, one person was at risk of falls. The person was unable to walk and used a full hoist for all transfers. The person also used a wheelchair to mobilise. Staff were guided that two staff members were required for all hoist transfers and one staff member required to push the person's wheelchair. During our inspection we observed staff following this

guidance. Where people were at risk of falls a 'diary of falls' document was held in care plans to enable staff to record incidents and look for patterns and trends relating to falls. Another person was at risk of developing pressure sores and a relevant risk assessment was used to assess and monitor this risk. A body map was used to monitor the person's skin condition and staff were also guided to reposition the person at regular intervals. Staff followed this guidance and the person did not have a pressure sore.

We however found when people had the pressure relieving mattresses in place there was no corresponding recorded guidance in relation to individual settings required. We looked at five different people who used three different types of mattresses and there was no information what the settings represented and no details of what these should be checked against. This meant people could have been at risk of developing pressure sores. We raised this with the registered manager who informed us no one suffered from a pressure sore and that they were going to audit the documentation relating to the mattresses to ensure this potential risk was addressed. Following our inspection we received confirmation from the registered manager that the information about the correct settings for individuals was added to charts where required. The registered manager also informed us they reviewed the mattresses and decided to only use the two types of pressure relieving mattresses.

People's medicines were managed safely. People told us they received their medicine as needed. Comments included, "They are good with my medicine, it's all ok" and "The senior person, you know the trained one, gives me my medicines and I just take what I'm given". We observed the administration of medicines and we saw that medicine was given to people in a professional and safe manner. People received medicines in line with their prescriptions and the medicine stock was kept securely in the drugs room. Medicines were stored in line with current guidance; the treatment room was locked when not in use and the nurse in charge held the keys. The medicines room was clean, tidy and organised. The temperature of the fridge, and room, were checked on a daily basis and were within the desired ranges. The Controlled Drugs (CD) were stored in a locked cabinet within the treatment room. The CD's were checked on each shift and there were no discrepancies. People who used transdermal medication (via a skin patch) had patch rotation charts in place. This meant the staff followed good practice as rotating patch sites minimises skin irritation.

Accident and incident recording procedures were in place and appropriate action had been taken where necessary. The registered manager used an electronic system to carry out a monthly analysis of accidents and incidents. This allowed them to identify any trends or patterns and identify any lessons learnt. The system was linked to the provider's head office so the concerns relating to health and safety, clinical issues or property could have been escalated to relevant departments for further support if necessary.

Good

Is the service effective?

Our findings

People told us staff were knowledgeable and knew how to support people well. Comments included, "They (staff) seem to know what they're doing, I think they must have training" and "Staff know how to look after me". One person's relative commented, "They (staff) got to know people's individual habits".

Staff told us and records confirmed staff received the training they needed to carry out their roles effectively. Staff commented the training received was very good. Comments included, "Training is very good here. It has given me confidence", "I've had induction, followed by all the training. This was all good" and "I definitely learned something on training". Staff were able to request additional training if they felt they wanted to improve their knowledge. One staff member said, "I once asked for dementia training and I got it". Staff received induction that reflected the Care Certificate. The Care Certificate is a nationally recognised set of standards that social care and health workers follow in their daily working life. Staff also received training in areas such as choking, Mental Capacity Act, Cardio Pulmonary Resuscitation (CPR) and customer care. The nurses were supported through the revalidation with Nursing and Midwifery Council (NMC). Revalidation is the process that allows nurses to maintain their registration with the NMC.

Staff felt supported by the management team. There was a system in place to provide staff with regular support sessions. Staff files and feedback reflected supervision sessions were ongoing. One member of staff told us they received supervision "Every two months, yes, on regular basis, a supervisor will chase us to ensure it's done". Another member of staff told us, "I am definitely well supported. I get supervisions. They tell me what I am doing well and where I can improve. I get them regularly".

Staff had a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA). 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 so that they can 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 Deprivation of Liberty Safeguard (DoLS). Where people were assessed as lacking capacity to consent to care and treatment and were considered to have restrictions to their freedom a DoLS was applied for. The team monitored the DoLS authorisation and ensured an application was submitted to the supervisory body before the end date of the initial authorisation. The registered manager ensured they had information about people's representatives. For example, one person had a relative appointed as having lasting power of attorney for their health and welfare. This authorised the appointed person to legally make decisions relating to the person's health and welfare on their behalf. The Office of the Public Guardian had authorised the appointment. This was clearly recorded in person's care file.

The registered manager ensured people's consent was sought... People had signed the risk assessments consenting to the use of bedrails. For example, one person used bedrails to enable them to feel safe in bed.

However, the person declined to have 'bumpers' fitted which increased the risk of entrapment. The care plan reflected the implications had been explained to the person and regular checks were in place to support the person's wishes. This meant the person's wishes relating to bedrails were respected.

People told us their wishes were respected. Comments included, "I just do what I want, when I want", "I can choose what I want to wear out of my wardrobe" and "They (staff) always give lots of choice and they respect my decisions". Throughout our visit we saw staff offered people's choices and they respected their preferences. For example, during the lunchtime meal we saw staff asking people, "Would you like me to put an apron on you?"

Staff we spoke with were aware of MCA principles and told us how they ensured people's rights were protected. Comments included, "It's about resident's rights and how they can decide. I give them help and offer them choices", "I offer choices for people in all areas so they can choose. I give them a few minutes to decide and I'll show them if they still don't understand" and "People got rights to make their own decisions. People should be allowed even to make their own mistakes if they have got capacity to do it".

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included the GP, care home support service (CHSS) and speech and language therapist (SALT). Visits by healthcare professionals, assessments and referrals were all recorded in people's care plans. For example, one person was referred to a speech and language therapist following a choking incident. The person was assessed and staff were provided with guidance on how to effectively support this person. This included ensuring the person was 'upright and alert' when eating and drinking and providing a 'soft fork mash diet' for the person. We observed staff followed this guidance at the lunchtime meal. One of the external health professionals commented, "They work very well with us".

People commented positively about the food. Comments included, "The food here is very good", "I get enough to eat", "The meals are fine, I choose what I want and if I don't like it they will get me something else" and "The food's very good on the whole". One person's relative told us, "Food looks very appetising, [person] is not eating well at the moment, they're giving them finger food". Another person's relative commented, "They mash up [person's] food so it's easier for them to eat since [person] came back from hospital". People received effective support to assist them to meet their nutritional needs. Where people were at risk of weight loss a malnutrition universal screening tool (MUST) was used to manage the risk. People were also regularly weighed. Food and fluid intake was monitored and all the records we saw evidenced people were maintaining their weight. The fluid intake charts gave clear information of the target amount required to be achieved and were fully completed. People's daily fluid intake was totalled up and monitored by a nurse on duty to ensure people received sufficient hydration.

We observed the midday meal experience. This was an enjoyable, social event where the majority of people attended. Food was served hot from the kitchen and looked 'home cooked', wholesome and appetising. People were offered a choice of drinks throughout their meal. People were encouraged to eat and extra portions were available. Where people required special diets, for example, pureed or fortified meals, these were provided. The chef had a list of people's requirements such as people's likes and dislikes and foods suitable for people with special dietary requirements. For example a vegetarian or celiac diet.

Good

Is the service caring?

Our findings

People commented positively on the caring nature of staff. Comments included, "Oh yes, the staff are very caring", "Honestly I think it's wonderful", "I like everything about the place, I can talk to any of the staff" and "They are all really nice". One of the external professionals told us, "The staff in Southerndown really do know their residents, from the carers to the domestic staff they all seem to genuinely care about their residents and want to do the best for them. They seem to recognise and respect their resident's different needs and treat all with respect and understanding".

During our inspection we observed numerous positive interactions between people and staff. For example, one person asked a member of staff for a hot drink. The staff member crouched down in front of the person, held their hand and asked what drink they wanted. The person smiled and stated they fancied coffee. The staff member got the person their drink and then asked if they wanted anything else. The person said "no but thank you for asking". There was clearly a genuine warmth and affection displayed by the staff.

People were cared for by staff that were knowledgeable about the support people required and the things that were important to people. We observed people who seemed to care about their appearance were helped with putting on jewellery or their chosen hair accessories. Staff knew the importance of providing personalised care. One staff member told us, "This is care, special to them, done their way". Another one added, "This is personalising care to that person, in a way that's best for them, not for me".

We observed staff communicating with people in a very patient and caring way, offering choices and involving people in the decisions about their care. People's feedback confirmed this. One person said, "I do feel involved with what is going on here". Another person added, "I usually get good personalised care". People were given options and the time to consider and choose. For example, one person came into the lounge and staff asked them where they would like to sit. The person considered this for a moment before pointing at a particular chair. They were then supported to their choice of chair and made comfortable by staff.

People's dignity and privacy were respected. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection and the language used in care plans was respectful. Staff gave us examples how they promoted people's dignity. Comments included, "I shut the door, close curtains and I knock on doors. I am respectful. I treat everyone how I would want my parents treated" and "I close doors and curtains to maintain their privacy".

People's independence was promoted. People told us the staff supported them being as independent as possible. One person said, "They do support my independence, I make sure they do". We observed staff asking people before carrying out support for them. For example, a member of staff asked one person during lunch, "Would you like me to cut up this for you?". People's records highlighted what tasks people were able to do and what level of assistance they required to be independent. For example, one person's care plan read, '[Person] is able to wash their hands and face and able to brush teeth but staff has to prepare toothbrush with toothpaste'.

People were looked after by staff that developed positive caring relationships with them and were enthusiastic about caring for people. Comments received from staff included, "We are all here because fundamentally we care", "The staff do care. We provide good care" and "We are definitely caring. I love it and the feeling I get from doing this work".

People's cultural needs were respected. For example, one person had stated they were religious and told us, "I like to attend church services". Daily notes, held in this person's care plan evidenced they regularly attended church service with the support of staff. People's files reflected people were supported to maintain their chosen diet as per their religious beliefs.

People were encouraged to personalise their bedrooms and people's relatives and friends had an unrestricted access to the service. One relative told us, "They're really good about visiting, I just come and go as I like". Another one said, "I just visit [person's] room when I want to, you don't need to ask".

People's advanced wishes relating to end of life were recorded in their care plans. People had stated where they wished to be cared for, details of family to be contacted and funeral arrangements. One person had registered themselves as an organ donor and we saw the provider had supported them in doing this. We noted do not attempt cardio pulmonary resuscitation (DNACPR) forms were contained in care plans and all those we saw had been appropriately completed. This included a 'patient directive decision' document that gave the person options to tick relating to their wishes. For example, one option provided the person choices relating to treatments and hospital admissions.

On the day of our inspection no one was receiving end of life care. However, staff recognised there were a number of people whose condition was slowly deteriorating and they were assessed as requiring tender loving care 'TLC'. This meant the staff ensured these people's condition was closely monitored. The weekly weight regime and food and fluid charts were in place to monitor people's well-being. We saw the charts were regularly completed. The staff told us they would seek doctor's involvement for example to request a pain control medicine should they note a change in people's condition.

Staff understood and respected people's confidentiality. One member of staff said, "We would keep files secure". Another member of staff told us, "We would not discuss people's issues in a pub or on social media". Records relating to people's care were stored securely in locked nurses' stations.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission to the service to ensure their needs could be met. People had been involved in their assessment and with planning their care and support. Comments from people reflected this and included, "I remember them asking about things I like, you know, food and stuff" and "I do feel involved with what is going on here".

Care records were detailed and contained people's personal histories, likes, dislikes, preferences and included people's preferred names, interests, hobbies and religious needs. One person's care file read, "I like to be called (their preferred name)". There was a resident of the day scheme which ensured people's care plans were regularly reviewed. An external professional told us, "Their notes are always very thorough and accurate, weight loss is very rarely an issue and information I look for such as assessments or care plans are almost always up to date and available".

The service responded to people's needs well. For example, one person's file reflected the staff observed signs of a possible urine infection. The staff immediately arranged for a urine test, referred the person to the doctor and encouraged increased fluid intake. The records showed the person commenced a course of antibiotics. The staff ensured the person's fluid intake was monitored closely and a fluid intake chart was started. Another person was assessed an unable to use their call bell. The person's file contained a clear guidance for staff and the plan of action which stated the person needed to be checked every hour. We saw the records that confirmed these checks were occurring.

People could choose what activity to engage in. For example, one person had stated they liked singing, bingo, quizzes and crossword. Daily notes evidenced this person was supported to pursue these activities and we saw them completing a crossword with a staff member. We observed the activities co-ordinator sat with a group of people discussing what to do. People were offered choices and they finally decided on a crossword. The activities co-ordinator then organised the crossword. Later in the day we saw several people engaged in an organised quiz. This was a lively affair with people laughing and clapping at other people's contributions. We observed people knitting. People could order newspapers and there was a library service that provided large print books if required. There were two pet rabbits kept in the garden and people told us about Archie PAT (pets at therapy) dog which visited weekly. One person said, "He's lovely, we all love Archie". Another person added, "I enjoy Archie's visits". One person had their pet budgie in their bedroom and spoke to us about it with affection.

People commented positively on activities. One person said, "Oh there's always stuff going on and always an activity after lunch, sometimes I join in, sometimes I don't". Other comments included, "She (the activity co-ordinator) is brilliant. I do join in as there is always something to do" and "I like to stay in my room and the staff are happy with that". A weekly activities planner was displayed in the lounge. Activities included religious services, hairdressing and manicure, musical events, pet therapy, games and one to one activities. Trips out of the home were also planned. For example, a trip to a local garden centre was planned for later in the week. The activity co-ordinator we spoke with was enthusiastic about their role. They told us, "I came here 3 years ago and absolutely love it, it's the best thing I've ever done, coming here. It's just so homely".

The activity co-ordinator was nominated for the Activity Co-ordinators' Award via the Great British Care Award Scheme this year and was awaiting the outcome.

People benefitted from a well-maintained environment. A secure garden area with unrestricted access was available for people to enjoy. The garden contained garden furniture, borders and raised flower beds allowing people in wheelchairs to access the flower beds if they wished. The ground was paved to allow easy wheelchair access. One floor on Memory Lane was not particularly dementia friendly. The corridors were painted in the same colour as people's bedroom doors. The door had very small cards with the person's name. Whilst doors were numbered this still meant people could have difficulty navigating around the unit. There was also limited dementia friendly equipment available to people that would stimulate their senses and prompt memories, people and events. We raised this with the registered manager who informed us this had been already recognised during an audit a few weeks ago. They told us a business case had been made to the head office requesting the refurbishment. The registered manager also told us the refurbishment was going to be in line with the 10/66 Project Dementia Research Group findings. The 10/66 Dementia Research Group is a collective of researchers carrying out population-based research into dementia, non-communicable diseases and ageing. The representatives of the project were scheduled to visit the service soon.

The provider had procedures for making complaints. Information about how to complain was available to people and visitors and displayed in the reception area. The complaint logs reflected four complaints were received since our last inspection. Three of them were closed and one was being investigated. We saw a number of thank you cards were displayed. People told us they knew how to complain. One person said, "If I had any worries I know I could go straight to the Manager". Another person said, "Yes I do know what to do to complain". One relative told us, "We had a problem once and it was sorted straight away. I'd go to the manager if I had any concerns".

People and their relatives were able to give their views in various ways. The provider used an external company called Your Care Rating to carry out their annual quality satisfaction surveys. This meant people had the opportunity to provide views and feedback via an independent and confidential survey. The surveys for this year were being sent out. We viewed the results of the last year's surveys and noted people were satisfied with the service received. People and their relatives were also able to attend resident's and relatives' meeting. We viewed the minutes from these meetings and noted issues such as the results of satisfaction survey or activities were discussed. One person told us, "I do attend and they (meetings) are good. I do think they are useful".

Good

Is the service well-led?

Our findings

The registered manager promoted an open culture that encouraged staff to participate in the running of the service. Staff said how much they enjoyed working at Southerndown. Throughout our inspection staff were cheerful and polite, with a ready smile for everyone. They did not appear to be phased by the inspection and were professional. The registered manager used regular staff meetings to reinforce the ethos of the service to the team. We noted in one meetings the registered manager used an innovative way to make the staff remember the principles of honesty and transparency. The minutes read, 'Remember as you're 'HOT' – Honest, Open and Transparent'. Feedback received from staff reflected the staff were aware of the culture. One member of staff told us, "I think it's an honest service. I am happy to own up to any mistakes I might make". Another member of staff said, "We are honest here. We look to fix errors, there is no culture of blame".

Staff spoke positively about the registered manager. They told us she was available and they felt listened to. Comments from staff included, "I really like [registered manager]. She's very supportive, helpful and definitely approachable. I think I know her well", "She comes on unit and goes to people's rooms when it's a resident of the day. She goes around, she's open and her office is open to go and talk at any time. And she's on call" and "She is approachable and friendly". The registered manager told us they were well supported by the provider's head office departments such as the property team, clinical development team and regulations team.

People also spoke positively about the registered manager. One person said, "I know the manager and all the staff. I think they are approachable. This is a fairly well run home". One visitor told us they had seen the registered manager walking around a few times but never had a reason to speak to her. However they felt they would be quite able to see her if needed.

Staff were encouraged to attend staff meetings. We noted there were clinical governance meetings, general staff meetings, health and safety meeting and unit meetings. The minutes from staff meetings reflected these were used to share learning between the team. Staff spoke positively about the meetings. Staff comments included, "We get handovers and briefings where we get updated. We also have staff meetings. I am well informed", "We share learning in handovers and staff meetings. Staff also share information amongst themselves" and "Manager asks all of us if we have any concerns and how to deal with these".

Additionally a daily 10 am meeting was also held between all heads of departments. This gave an opportunity to discuss any ongoing issues and ensure good communication was maintained. For example, the registered manager advised the chef two people had dentist appointments so an early lunch was required for them and this was arranged.

The provider had a whistleblowing policy and the staff we spoke with were aware of it. They were also aware of the whistle blowing policy and poster displayed in the staff room. Staff told us they would not hesitate to report any safeguarding concerns to the senior person on duty, the registered manager or head office. Staff were also aware they were able to report outside the organisation. One person said, "We have

(whistleblowing line) number to ring. Or would go to social services, social worker or Care Quality Commission (CQC)".

The provider had systems in place to monitor the quality of the service. The audits included medication, kitchen, care documentation, dining room observation and unannounced site visits carried out outside of office hours. The registered manager provided a monthly report to the provider with data about a range of information including falls and people's nutrition. The provider analysed this data to look for patterns or trends that could indicate something that could be prevented. The service was also subject to audit by provider's internal regulations team. The registered manager also ensured Duty of Candour reports were completed when required. Where any of these quality assurance systems identified actions the registered manager ensured these were addressed. For example, the registered manager identified there was a delay in reporting an incident due to the nurses being unable to access the internet. This had been addressed and the senior staff were now able to access the internet in the registered manager's absence.

Any issues identified during audits were compiled into an ongoing action plan with dates for completion. We saw the action plan reflected the planned refurbishment of the dementia unit. Additionally a number of health and safety audits were undertaken to ensure the safety and welfare of people and staff. We saw the evidence the checks of environment included water temperatures, emergency lights checks, fire alarm checks and maintenance bedrooms inspections.

The registered manager promptly followed up and acted on feedback received from surveys and questionnaires. For example, people voiced they wanted to be able to use internet to stay in touch with families. The registered manager ensured a wireless broadband connection was available and two tablets were purchased to enable people to use the internet to make a contact with their families. This information was also displayed on the "You said, we did" board in the reception.

The team at Southerndown worked with other organisations to ensure the service followed best practice and people received appropriate support. People's care records reflected working with local multi-disciplinary teams, which included the local surgery or the local social services teams. One of the external health care professional commented positively of the service and told us they "Always spoke very highly of the home".