Tamaris Healthcare (England) Limited

Maple Lodge Care Home

Inspection report

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27 May 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 24 and 27 May 2016. The first visit on 24 May 2016 was unannounced. The second visit on 27 May 2016 was announced. We last inspected the service in May 2014 and found the service met the regulations we inspected against at the time.

Maple Lodge is a care home which provides nursing and personal care for up to 46 people, some of whom may be living with dementia. There were 44 people living there at the time of our inspection, 10 of whom were accommodated on a 'Time to Think' assessment unit which gives people the opportunity to trial residential care.

The service had a 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.

We found the provider had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider did not have accurate records and procedures to support and evidence the safe administration of 'when required' medicines and prescribed creams.

You can see what action we told the provider to take at the back of the full version of the report.

On both days of our inspection there was a homely atmosphere. Staff interacted with people in a friendly and respectful way. People were encouraged and supported to maintain their independence and to pursue their interests and hobbies. The service was clean and well decorated.

People and relatives told us they felt the service was safe. One person said, "I feel safe as the staff take care of everything. I'm happy here because it's great." Another person told us, "It's lovely here as we get well looked after. I've got no problems whatsoever."

Staff we spoke with said they had completed safeguarding training and could describe different types of abuse and signs to be alert to. Staff told us they would report any safeguarding concerns immediately.

The provider made sure only suitable staff were employed. Thorough background checks were carried out before staff started to work with people who used the service.

There were regular reviews of people's health and care needs and staff responded promptly to any changes. People saw health and social care professionals to ensure they received treatment and support for their specific needs.

People's dietary needs were met. People were provided with a choice of meals and had access to regular snacks and drinks throughout the day.

People who used the service told us they were well looked after and staff were caring. One person said, "I love the girls here as they look after me so well. They're marvellous." Relatives also spoke positively about the caring attitude of staff. One relative told us, "I'm really happy with the care [family member] receives."

Care plans were detailed and specific to people's individual needs. They were reviewed and updated regularly. When people's needs changed this was acted on promptly.
People knew how to make a complaint and were given information about the service.

People who used the service, relatives and staff told us the registered manager was approachable and efficient.

There were effective quality assurance processes in place to monitor care and safety and identify improvements. The views of people who used the service, relatives, staff and other health care professionals were frequently sought.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The provider's procedures did not support the safe administration of medicines.

People and their relatives felt the service was safe.

Thorough checks were carried out on all staff before they started to work at the service, to check they were suitable to care for and support vulnerable adults.

Checks on the maintenance of the premises were carried out regularly.

The accommodation was clean, comfortable and well decorated.

Is the service effective?

Good

The service was effective.

Staff received training that enabled them to be effective in their role.

People were asked for consent before care was provided.

People were supported to maintain a healthy diet.

The service met the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People who used the service said staff were caring, considerate and helpful.

Relatives said staff were patient and maintained people's dignity.

Staff knew people's needs and preferences well.

Staff spent time talking with people and sharing a joke.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and informative.

Staff responded quickly when people's needs changed.

People and relatives knew how to make a complaint.

A range of activities was available to occupy people in a meaningful way.

Is the service well-led?

Good

The service was well-led.

People who used the service, relatives and staff told us the registered manager was approachable and efficient.

Quality assurance systems and processes were effective in monitoring the quality of the service provided, and identified when improvements were necessary.

The provider sought frequent feedback from people, relatives, staff and other health care professionals.

People's feedback was acted upon and communicated.

Maple Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place over two days. The first visit on 24 May 2016 was unannounced which meant the provider and staff did not know we were coming. The second visit on 27 May 2016 was announced. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the PIR and all the information we held about the service, including the notifications we had received from the provider, before the inspection. Notifications are changes, events or incidents the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service, the clinical commissioning group (CCG), the local safeguarding team and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We did not receive any information of concern from these organisations.

We spoke with eight people who used the service and six relatives. We also spoke with the regional manager (representative of the provider), two nurses (one of whom was the clinical lead), one activities co-ordinator, five care assistants, kitchen staff, domestic staff and the maintenance person. The registered manager was absent due to annual leave at the time of our visit, but the clinical lead, administrator and the provider's regional manager assisted us for the duration of the inspection.

We looked at a range of records which included the care records for five people who used the service, medicine records for 16 people, training and recruitment records for four staff, and other documents related to the management of the service.

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.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed in the right way. People's care plans and medicine records lacked guidance for staff relating to 'when required' medicines. Several people were prescribed pain relief such as paracetamol 'when required', but there was no care plan or guidance in place to assist staff in their decision making about when it could be used. Staff described when they would administer 'when required' medicines but there was no clear guidance for them to refer to. This meant there was no information for staff to follow about indications that a person may need their medicine. It is important staff have this information for people who may not be able to communicate their needs fully. This meant we could not be sure 'when required' medicines were administered safely.

Four medicine records we viewed contained handwritten instructions signed by one staff member instead of two and there was no record of who had authorised the changes. This meant there was the risk of error as there was no clear line of accountability for changes which put people at risk of not receiving the correct medicines. Handwritten entries should be checked and signed by a second trained staff member in line with the National Institute for Health and Care Excellence (NICE) guidelines.

Appropriate codes for the non-administration of medicines were not always used. For example, code X had been used on medicine administration records (MARs) when medicines that weren't prescribed daily weren't to be administered, but this was not a standard or correct code for the type of MAR used at this service. This meant accurate records were not always kept when medicines were not administered.

Prescribed creams were not recorded as administered on topical medicines application records (TMARs), and body maps to highlight where staff should apply the creams and ointments were not in place. This meant we could not be sure prescribed creams had been administered in the right way or at the right frequency, in line with the instructions on people's prescriptions. When we asked the regional manager about this they told us the provider was implementing a new medicines policy in the coming weeks which would ensure that TMARs and body maps were used for prescribed creams.

On nine days in the last three months and during our visit, the recorded temperature in the ground floor treatment room, where medicines were stored, was above that recommended for the safe storage of medicines. We noted that staff had taken steps to reduce the temperature by putting a fan in the room, but the temperature remained above recommended limits during our visit. When we spoke to the regional manager about this they said they would address this.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service operated a monitored dosage system (MDS) for administering prescribed medicines, with medicines supplied on a 28 day cycle. A MDS is where medicines are pre-packaged for each person, according to the time of day. We saw people received their medicines at the time they needed them. We checked 16 MARs for the past four weeks and found no gaps or inaccuracies in relation to routinely

prescribed medicines. This meant people received their routinely prescribed medicines as directed.

We observed one of the nursing staff doing the morning medicines round. They spoke to people in a gentle, supportive and encouraging way. They said, "Good morning, how are you today? Can I give you your tablets? Have a little drink of juice with them." People were given enough time to take their medicines.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the use of controlled drugs so as to readily detect any loss. The controlled drugs register had been completed accurately which meant the arrangements for controlled drugs were safe.

Dates of opening and expiry were written on medicines such as eye drops and creams. This meant medicines were used when they were considered most effective. A clinical fridge in the treatment room was checked daily and was within recommended limits.

We asked people, their relatives and staff if the service was safe. People who used the service told us they felt safe living at the service. One person said, "I feel safe as the staff take care of everything. I'm happy here because it's great." Another person told us, "It's lovely here as we get well looked after. I've got no problems whatsoever."

The provider had received recent written feedback from people who used the service which included comments such as, 'I feel safe because the staff are great here', 'I have a buzzer if I need help quickly so I'm very safe' and 'Staff are on hand all the time so I feel safe.'

A relative said, "[Family member] had bad experiences of care before they came here, but this is a nice place and [family member] is settled and very safe." Another relative told us, "My [family member] is safe here. Their mobility is variable but I know staff can't be there all the time."

A staff member told us, "People are safe here as staff know what residents they are responsible for and staff are always around. Also, nursing staff are always around to answer questions from care staff." Another staff member said, "Staff supervise people and make sure they're safe."

Staff told us and records confirmed, they had received training in protecting adults from abuse and how to raise concerns. They were able to demonstrate the action they would take and tell us who they would report concerns to in order to protect people. Staff understood the different types of abuse and knew how to recognise signs of potential abuse and understood their responsibilities to report issues if they suspected harm or poor practice.

One staff member told us how they had raised a safeguarding issue recently and this had been dealt with appropriately by the registered manager. The staff member explained the registered manager reported the issue to the local safeguarding team, discussed the matter with the person's family and referred the person to the local falls team. Another staff member said, "We always encourage people and families to raise any concerns." Staff we spoke with felt safeguarding concerns were taken seriously.

The service employed approximately 50 staff. There were two nurses, eight care assistants and one activities co-ordinator on duty during the days of our inspection. Staff rotas we viewed showed these were the typical staffing levels for the service. The service also employed laundry and domestic staff, kitchen staff and one maintenance person. Night staffing levels were one nurse and four care assistants. The regional manager told us the registered manager didn't use agency shift as they have regular bank staff and permanent staff prefer to work any extra shifts that need covering. There were sufficient staff on duty as call bells were

responded to promptly and people were supervised appropriately.

The provider used a specific dependency tool called 'CHESS' to determine staffing levels in the service. The regional manager told us people were categorized into low, medium and high dependency based on their individual support plans, and records confirmed this was reviewed regularly.

Regular planned and preventative maintenance checks and repairs were carried out by the maintenance person. These included daily, weekly, quarterly, and annual checks on the premises and equipment, such as fire safety, window restrictors, nurse call system and water temperatures. Other required inspections and services included electrical and gas safety. The records of these checks were up to date.

The maintenance person spoke enthusiastically about their role and told us how they did a visual check of all areas daily to ensure fire extinguishers were where they should be and that doorways were clear. They told us staff logged issues in a maintenance book which they prioritised so that priority issues took precedence over routine maintenance. The maintenance person told us, "It's for my peace of my mind to keep everything safe for people. My main priority is the safety of the people who live here."

Accidents and incidents were recorded accurately and analysed monthly in relation to date, time and location to look for trends. Although no trends had been identified recently, records showed appropriate action had been taken by staff. For example, paramedics were called after a person had an unwitnessed fall, the person was referred to the falls team and their observations were increased when they returned home.

Risks to people's health and safety were recorded in people's care files. These included risk assessments about people's individual care needs such as falls, pressure damage and nutrition.
Control measures to minimise the risks identified were set out in people's care plans for staff to refer to.

Risk assessments relating to the environment and other hazards, such as fire and food safety were carried out and reviewed by the registered manager regularly. Each person had a personal emergency evacuation plan (PEEP) which contained detail about people's individual needs, should they need to be evacuated from the building in an emergency. They contained clear step by step guidance for staff about how to communicate and support people in the event of an emergency evacuation. For example, one person's PEEP stated, 'Carer to explain what is happening to reduce anxiety.'

Thorough recruitment and selection procedures were in place to check new staff were suitable to care for and support vulnerable adults. People's identification and employment history were checked, and a disclosure and barring service (DBS) check had also been carried out before staff started work. These checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The regional manager told us DBS checks were repeated every three years, which was good practice. Nursing staff had up to date registration with the Nursing and Midwifery Council.

The service had a relaxed and homely feel. The premises were clean, comfortable and well decorated.

Good

Is the service effective?

Our findings

We observed breakfast and lunch during our visit. People told us the food was nice. One person told us, "Oh yes the food's lovely." Another person said, "I couldn't wait to have my lunch as the food is lovely." One relative told us, "The meals are lovely." Another relative said, My [family member] loves the food here."

On the ground floor meals were served straight from the kitchen by kitchen staff into the adjacent dining room. On the first floor meals were transported from the kitchen via a service lift and served by care staff. Cooked breakfast items were transported on serving plates and then each person was served in turn. As food was not kept in a hot lock trolley or similar, we could not be sure people's cooked breakfasts were hot by the time they were served. We raised this with the regional manager who arranged for the provider's peripatetic chef to assess and rectify this.

People were given a choice of meals. One staff member said, "If you don't like it don't eat it. We can easily get you something else don't worry." Staff told us if people had limited communication they knew what people's food preferences were from people's support plans. Staff knew what people preferred to eat and drink, such as one person liked the crusts cut off their toast and another person preferred a glass of milk to tea and coffee. At breakfast people had a choice of cornflakes, porridge, toast, cooked breakfast, juice, tea and coffee. There was a nice buzz in the dining room as people and staff enjoyed friendly conversations. Menus were displayed in the dining room in picture format to assist people living with dementia.

The dining rooms looked pleasant as tables were set with table cloths, placemats and cutlery. Four care assistants supported people in each dining room. There were enough staff to support people at meal times. If people weren't eating much staff encouraged them to eat a bit more or offered alternatives. Staff also offered seconds to people who had eaten all of their meal. Staff chatted to people and asked "What would you like for your breakfast? Do you want some more coffee?" Staff encouraged people to eat by saying things like, "Would you like to try a little egg sandwich and see how you get on?" Staff supported people to leave the dining room when they wanted to leave.

Staff knew if people needed a specialist diet and what level of support they needed to eat or drink. Staff told us which people who used the service had been assessed by a speech and language therapist as needing a specialist diet and what guidelines to follow such as a pureed diet. There was specific guidance in care plans to support people's nutritional well-being and ensure their safety. For example, one person's care plan stated, 'Staff to support [person] by giving small bite size portions of food and encourage good fluid intake during meals. Limit distractions during meal times such as loud talking, music or other distractions.' This meant staff had access to information about how to support people to maintain a healthy diet.

People's food and fluid intake was monitored where appropriate, and fluid intake goals and totals were recorded which was good practice. People's weight was monitored and any issues were referred to other professionals. People had access to a wide range of health care professionals such as dentists, the challenging behaviour team, community psychiatric nurses, and podiatrists. Records of visits by other health care professionals were clear and detailed. Staff told us they had a good relationship with other

health care professionals, which was a benefit to people who used the service. One staff member told us, "The input from the community psychiatric nurse has been very useful in helping one person settle. Also, we can go through the GP to make a referral to the dietician and get the advice and guidance we need. The district nurses see our residents regularly and we can ring them any time." Staff also told us how they received training from a challenging behaviour clinician to help them support a person whose behaviour may challenge others.

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. New staff completed an induction programme which included training on safeguarding vulnerable adults, health and safety, food hygiene and moving and assisting. One staff member said, "I learned a great deal on induction and felt confident knowing how things work and where things are kept." Staff completed further training at regular intervals on issues such as infection control, allergen awareness, and the Mental Capacity Act 2005.

Staff told us they received enough in house training and computer based training for their job role. One staff member said, "Yes I've had enough training." The provider had received recent written feedback from a staff member which stated, "We get loads of training."

Staff told us, and records confirmed, they had regular supervision sessions and an annual appraisal with their managers. The purpose of supervisions was to promote best practice, offer staff support and identify any areas for development. Records confirmed staff had individual supervision sessions every two months, and these were planned for the rest of the year. Supervisions were up to date. Staff told us they felt supported by the registered manager and each other. One staff member told us, "We get support from the home manager without question."

Staff handovers took place at each shift changeover. These give staff the opportunity to discuss people's care and treatment, communicate problems and concerns and ensure everyone knows what is going on. Handovers at the service were effective as all care staff attended and they were detailed.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's care records contained best interest decisions which corresponded to the information contained in the DoLS authorisations. One person's care plan contained clear guidance for staff regarding the process to follow regarding best interest decisions. It stated, 'Before any complex decisions are made a multi-disciplinary meeting should be arranged involving all appropriate health care professionals and [person] family. All best interest decisions should always take into account [person] past and present preferences.'

Where people required a DoLS authorisation there was a record of when authorisations had been granted.

The registered manager kept a record of DoLS expiry dates so new applications could be made in a timely manner. 27 people in the service were subject to DoLS.

The service had features which supported people living with dementia such as brightly coloured signs on doors, memory boxes outside people's rooms to help them recognise their own room, reminiscence material such as a washing line and a sensory room. There was also a reminiscence room with rummage boxes, old photos and bookcases. This was in line with the Department of Health guidance document, 'Dementia-friendly Health and Social Care Environments' (March 2015) which gave a range of examples of how memory boxes, memorabilia and rummage boxes can enhance people's involvement and meaningful inclusion in their environment.

Good

Is the service caring?

Our findings

People who used the service told us they were well looked after and staff were caring. One person said, "I love the girls here as they look after me so well. They're marvellous." Relatives also spoke positively about the caring attitude of staff. One relative told us, "I'm really happy with the care [family member] receives." A second relative said, "The staff are brilliant. They've got time for everyone. They are patient and maintain people's dignity." A third relative told us, "The care staff are spot on. I'm very happy with the home."

People and their relatives told us they had developed good relationships with staff members. A relative told us, "I would recommend this home to anyone as the staff are friendly and caring. They always speak to me when I come to visit. They're absolutely excellent as they always explain to [family member] what's going on and what they're doing. The staff are the right people for the job." Another relative said, "It's great here. My [family member] is really happy and well looked after here."

The provider had received written feedback from people who used the service which included comments such as, 'I love it here as everyone gets on well. Staff are friendly and considerate and treat me with respect. Staff listen to me and help me make decisions,' 'Staff are so helpful and lovely. They know what I like and what I want to do,' and 'The staff keep me in good spirits. They knock on the door and treat me very well.' The provider had also received written feedback from relatives which included comments such as, 'It's a lovely home with lovely staff' and 'Staff are caring and will always go the extra mile.'

Some people were unable to fully communicate their opinions about the care they received, but we observed positive relationships between staff and people living at the service. Throughout our visit staff spoke to people in a kind and considerate manner. Staff knew people well, particularly those who were not always able to express their wishes clearly. There was a relaxed and friendly atmosphere and people regularly shared a laugh and a joke with staff. When people needed comfort or reassurance this was done sensitively and appropriately by holding the person's hand, for example. We also observed staff spending time with people having a chat or encouraging them to take part in an activity staff knew they liked. One staff member said, "Would you like to come with me and have a sit down and a chat? Or do you fancy watching a film?" One person said, "Staff are always willing to sit and listen."

People were given choices about where they wanted to go, what they wanted to do and were asked for permission before staff supported them. For example, one staff member said, "Do you want to go to the lounge or your room? Would you like me to help you?"

The name of the nurse in charge of each floor was prominently displayed in communal areas for people and visitors to see. This was kept up to date for people, relatives and staff to refer to.

Staff told us they took pride in ensuring all of people's needs were met whilst encouraging their independence. One staff member said, "It's all about people's choice and helping them maintain their independence. I love the residents like my family. We know people and their families well." A second staff member told us, "Staff are kind, caring and attentive to people's needs. We ensure people have everything

they need." A third staff member told us, "People get treated with dignity and respect here. Our standards are high."

Staff also told us they liked working at the service. One staff member said, "I like working here as I enjoy the interaction with residents." A second staff member told us, "It's a happy place to work as we all get on, staff, residents and families. We support and reassure families." A third staff member said, "I love working here because it's so fulfilling. I love talking and interacting with the residents as it's rewarding. It's a lovely care home."

An occupational therapist who was at the service during our visit told us, "Staff do a great job of looking after people. I would put my family here."

The service had received several written compliments from relatives which included, 'Thank you for looking after [person] and making the last few months of their life happy and comfortable,' and 'With many thanks to everyone for your care and kindness during my stay with you. It's much appreciated.'

Information about advocacy support from external agencies was readily available. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions. The administrator told us three people who used the service had an advocate.

People's wishes for end of life care were documented in their care records. Where a person was unable to fully communicate their wishes a discussion had taken place with relatives and recorded appropriately.

Good

Is the service responsive?

Our findings

We looked at five people's care records to assess if staff were provided with the information they needed to provide appropriate care and support for people. People's needs were assessed before admission to the service. For example, people's medical, nutritional, psychological and mobility needs were taken into account. These were set out appropriately in care plans and reviewed regularly.

Care plans were well written and contained information about people's life history, family background, daily routine and specific care and support needs. This information was person centred and there was precise detail around daily tasks. For example one person's care plan stated, '[Person] is unable to verbalise pain but will express pain through facial expressions.' Another person's care plan stated, 'Encourage [person] with high calorie snacks to maintain a healthy weight.' This meant staff had appropriate guidance on how to provide person-centred care to people. One staff member told us, "We give people individualised care here as what works for one person doesn't always work for another."

People had been involved in decisions about their care, where capabilities allowed. Relatives we spoke with said they felt involved in planning and reviewing their family member's care. One relative said, "Staff involve me in all decisions about [person] care and always keep me up to date with what's going on."

Care plans were reviewed regularly and whenever a person's needs changed. Records of reviews identified where changes were required and care plans were updated accordingly. For example, one person had lost weight which resulted in a referral to the dietician. The dietician's recommendations were included in the care plan and carried out by staff. In another care plan records showed a care worker noticed deterioration in a person's skin condition so they sought advice from one of the nursing team. Staff intervention enabled the pressure area to heal quickly.

Staff responded to changes in people's needs quickly and appropriately. During our visit staff noticed one person was confused so they contacted the person's GP as they suspected the person had an infection. Another person complained of earache so they were seen by the GP. A staff member told us, "Staff are quick to respond when people's needs change and write this in care plans. Staff know what's in people's care plans." Another staff member said, "Everyone's needs are different so we adapt to that person."

The service employed an activities co-ordinator who organised a range of social events, activities and social entertainment. Activities included a seaside walk for 'senior fitness day', dominoes, jigsaws, board games, bingo, movie afternoons and 'sit and be fit.' The activities co-ordinator told us they completed an activities assessment on each person on admission to the service, and they also asked relatives what interests the person had. The activities co-ordinator produced a monthly newsletter which advertised activities for the coming month. Future events included D-day commemoration, summer fete, pub lunch and songs of praise with a local gospel choir. There were lots of photographs of people enjoying activities displayed throughout the service.

The provider had a clear complaints policy which was up to date. There was information about how to make

a complaint in the residents guide which was given to people on admission. The registered manager kept records of any complaints including the nature of the complaint, actions taken and the outcome.

People and relatives told us they would speak to staff or the registered manager if they needed to make a complaint. One relative said, "I've got no complaints or concerns. If I did, I would go straight to the manager." Another relative told us, "I've got no complaints as it's excellent here. Staff are great at keeping me informed if anything happens."

The registered provider used a real time electronic system for gathering feedback from people, relatives and other health care professionals using devices located in the reception area. This meant feedback could be given anonymously at any time and analysed immediately by the provider. We viewed recent feedback which had been positive. Comments from health care professionals included, 'Staff are knowledgeable' and 'Staff are always helpful and can provide good feedback on residents.'

Good

Is the service well-led?

Our findings

The service had a registered manager who had been in post for several years. The registered manager was absent due to annual leave at the time of our visit, but the provider's representative (regional manager), clinical lead and administrator assisted us for the duration of the inspection. The representative of the provider told us, "The registered manager is a good leader with a positive attitude. They're a qualified mental health nurse so they'll cover nursing shifts. They've got a good team here. Staff have pride in the service."

People and relatives told us the registered manager was approachable and efficient. A relative told us, "The manager is fair and approachable." The provider had received recent feedback from relatives which included comments such as, 'The manager is good. They know their job and they're firm but fair' and 'The manager does their best for the home and the residents.' The provider had also received recent feedback from health care professionals who had visited the service, which included comments such as, 'I am extremely likely to recommend this service to friends and family', 'This is a well-run home' and 'The manager has been in this home for years and is very good.'

The views of people, relatives and staff were frequently sought. The representative of the provider told us they set weekly targets for obtaining feedback as they felt an annual satisfaction survey or similar was ineffective as they often had a low response rate. Feedback we viewed from the last three months had been positive. When one less positive comment had been made this had been responded to appropriately and in a timely manner by discussing the relevant issues in staff supervision and completion of additional training. This meant feedback was acted upon. A suggestion box was also available in the reception area, so people, relatives and staff had several ways of providing feedback on the quality of the service.

In the reception area a board was prominently displayed which stated 'what we asked, what you said and what we did'. The most recent example of this was people were asked which area of the service they would like revamped and they said the dining room. This resulted in the dining room being redecorated which meant the service responded to people's feedback and communicated this.

Residents' and relatives' meetings were held every two months and dates were scheduled and advertised for the rest of the year. These meetings were led by the registered manager and the activities co-ordinator. Minutes of the last meeting on 4 April 2016 showed that people discussed forthcoming events and the menu. Some relatives we spoke to said they felt they didn't need to attend these meetings as they felt able to approach staff at any time.

Staff told us the registered manager had an open door policy and they could go to them at any time. A staff member told us, "[Registered manager] is a competent manager. They'll always listen to suggestions from staff to improve things for residents. They are approachable so I can go to them for advice." Another staff member said, "We can talk to the manager without any problems as their door is always open and they're friendly."

Staff meetings were held every two months. Minutes of the last staff meeting on 3 May 2016 showed that minutes of previous meetings and actions arising were discussed, together with standard agenda items such as feedback and training. There was also an opportunity for staff to raise any issues under 'any other business.' Minutes of staff meetings were produced so staff not on duty could read them at a later date.

The provider ensured the quality of the service was assessed and monitored by carrying out regular audits of all aspects of the care provided. Areas audited included care plans, medicines, health and safety checks and premises checks. The registered manager completed monthly audits which were followed up by a 'quality visit' from the provider's regional manager. They completed an improvement plan with timescales which set out areas which required attention, and this was reviewed to ensure appropriate action had been taken.

The service had good links with the local church and primary school. Children from the local primary school enjoyed an Easter egg hunt at the service, and the local vicar visited regularly to lead worship for those people who wished to attend.

During the inspection we asked for a variety of documents and information. These were provided promptly and we found the registered manager had ensured records regarding people's care were accurate, up to date and orderly.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with unsafe or unsuitable care and treatment because records and systems did not support the safe management of medicines. Regulation 12 (2) (g).