Altogether Care LLP

Weymouth - Weymouth Care Home

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

Weymouth Care Home is registered to provide accommodation with nursing care for up to 35 people. There were 32 people living in the home at the time of our visit, some of whom were living with dementia as well as other conditions such as parkinson's disease and diabetes. The home is organised across two floors. There is a passenger lift to allow easy access to the first floor. The majority of rooms have ensuite facilities. There is a communal dining area, a lounge, and a library which is used as a quiet area for people to spend time with friends and relatives.

There was a registered manager in post. This person started as manager at the home in March 2018 and became registered manager in July 2018. 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.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good.

People felt safe. They were supported by staff with a good understanding of how to safeguard them and how to raise concerns either internally or externally if they suspected harm or abuse. There were enough staff to meet people's needs. A dependency tool was used to help ensure that staffing levels continued to match the needs of the people living there. People's individual risks were assessed and reviewed.

The home carried out monthly accident and incident audits. This included a description of what had happened, the result of the investigation, and follow up action taken. This helped reduce the risk of things happening again.

People had thorough pre-assessments to support their move to the home. These included people's needs, preferences, social background and their abilities. People were supported by staff who had received an induction. This involved shadow shifts with more experienced staff and regular competency checks. People were supported to eat a balanced and healthy diet. They were given choice of what to eat and drink and could eat as much or as little as they wanted. Snacks were available to people outside of typical meal times. Where people required extra support with eating and drinking this was provided in line with guidance from health professionals.

People were supported to access health services such as dentists and dieticians to help maintain their health and well-being. Where people's health needs changed there was timely contact with relevant health professionals. People were supported by staff who understood the importance of offering choice and support in line with what they needed and wanted. This gave people the opportunity to live their lives how they wanted to.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Where people lacked capacity to make particular decisions they were supported by staff who were trained and worked in line with the principles of the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides the 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 capacity to make particular decisions, any made on their behalf must be in their best interests and least restrictive as possible.

Staff consistently demonstrated a kind and caring approach towards people. People's privacy and dignity were supported at all times. They were given time and space to spend private and uninterrupted time with friends and relatives. People were encouraged to maintain their independence.

There was a varied and well publicised activities programme at the home supported by a new activities coordinator. The programme included group activities and 1:1 sessions in people's rooms. These activities supported people to maintain their interests, develop new skills, and helped reduce the risk of isolation.

People were supported to maintain contact with family and friends. Relatives told us they could visit freely and were always made to feel welcome and involved. Staff were aware of people's different communication needs and provided information in a way that was most beneficial for them. The home managed complaints in line with their policy. People and relatives expressed confidence that when issues were raised they were dealt with in a timely way and to their satisfaction.

Staff told us they enjoyed working there and felt supported by colleagues and the management team. Opportunities were provided for personal development. Regular team meetings were held to share information and learning. Annual surveys were used to find out how the service people received could be improved.

The home had developed good working relationships with healthcare professionals. This had resulted in pro-active in-reach services from GPs, hospice nurses and a local tissue viability team. These links helped to keep people well for longer and prevent unnecessary hospital admissions.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Weymouth - Weymouth 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 on 10 and 11 September 2018. The first day was unannounced with the second day announced. The inspection was carried out by a lead inspector 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.

Typically in planning inspections, we use information the provider sends to us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during the inspection. Before the inspection we reviewed the information that we had about the service including safeguarding records, complaints, and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

The inspection was prompted by contract monitoring reports we received from the local authority contract monitoring team and clinical commissioning group. This followed joint monitoring visits they did in April, July and August 2018. They identified improvements were needed in areas including: skin care plans, fluid intake, the provision of 1:1 activities for people at risk of social isolation, storage of continence aids, accessibility of call bells, and the safeguarding of people's personal information. The reports helped inform our inspection plan and led us to explore the identified areas in more detail. We also reviewed the action plan the home had developed to resolve the issues.

During the inspection we spoke with nine people using the service, and six relatives. We also spoke with the

registered manager, six care staff, two chefs, the part time activity coordinator, head house keeper, and two domestic assistants.

We looked at five people's care plans. We also looked at records relating to the management of the home including staff rotas, medicine administration records and meeting minutes. We looked at four staff files, the recruitment process, complaints, training and supervision records. After the inspection we spoke to two health professionals - a tissue viability nurse, and a GP that visits weekly, to get their views on the care that people receive.

We pathway tracked three people. Pathway tracking is where we review records and do observations to see if people are supported in line with their assessed needs. Some people were unable to tell us their experiences of living at the home as they were living with dementia and were unable to communicate their thoughts. We therefore 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.

Following the inspection, we asked the registered manager to send us some policies, training information and audits. These were all sent within the time frame requested.

Good

Is the service safe?

Our findings

People were supported by staff who understood how to safeguard them from harm or abuse. They knew the signs to look out for which could indicate a person was at risk of harm or abuse and who to speak to both internally and externally. One staff member said, "I'd definitely be confident in raising a concern or whistleblowing. You should always think 'would you want your mum treated like that?'" People told us that they felt safe at the home. Two people said, "The staff are good and make me feel safe" and, "I feel this is a safe place to live." A relative told us, "I definitely feel [name] is safe here."

People's individual risks were managed well including risks to their skin. People who were at risk of damage to their fragile skin had personalised repositioning care plans in place. This was to reduce pressure on high risk areas. Care plans noted when people could reposition themselves in bed. Records showed that staff had supported people as prescribed by the tissue viability team including welfare checks at the correct time intervals and frequency and the application of skin creams. On occasions where two staff had been required to support a person both had completed a daily note of what they had done which was in line with the person's care plan.

Where people were using pressure relieving equipment such as air mattresses these were checked and on the correct setting that each person required to help maintain their skin integrity or aid healing. Where people's equipment had not given the required benefits and protection, staff had contacted the relevant health professionals and obtained alternative equipment. On occasions where people had pressure damage to their skin, photos had been taken with consent, or as part of a best interests decision, to allow tracking of the wound during a treatment plan. Staff had completed body maps and were applying barrier creams as prescribed in people's individualised plans.

Equipment within the home was routinely serviced. This included the fire system, slings and temperature regulators on taps. Monthly fire drills had taken place and staff confirmed they had recently received fire training. People had Personal Emergency Evacuation Plans (PEEPS) in place. These guided staff on how to evacuate people safely in the event of an emergency. These were reviewed to ensure they documented people's current needs and abilities. The home had a maintenance log which documented areas that needed attention and action taken or required to resolve them. General risks assessments were carried out which reduced risks to people, relatives, visitors and staff within the home environment.

There were enough staff to meet people's needs. The home used a dependency tool to help match staffing levels to the level of care and support people required. The registered manager said this was reviewed if people's needs changed, people passed away, or new people came to live at the home. Staff did not appear rushed but one staff member said sometimes they can be pressured. Two relatives said, "It is a very busy place so sometimes things get hectic" and, "There is good support within the confines of a very busy care home." This was raised with the registered manager who told us they are advertising for another head of care, a night nurse, a weekend cleaner and another kitchen assistant.

People were able to call for help using call bells or pendants. When people used their calls bells we observed

staff responding in a timely way. These had been placed within their reach. For people who lacked capacity to understand how to use a call bell, and its purpose, we observed that these were still available in their rooms should staff or relatives need to call for help on their behalf. The home kept a log of call bell response times which the manager reviewed regularly to ensure staff were responding to people in a reasonable time. Two people said, "My call bell works as required", and "I generally get a good response when I use my pendant."

Recruitment practices at the home meant that people were supported by staff suitable to work with vulnerable adults. Staff only worked with people once they had received the necessary clearances.

Medicines were managed safely. People received support from staff who had received training and up to date competency checks to ensure they could do this task well and minimise the risk to people. The home used an electronic medicines system available to staff via a password protected hand held device. Staff had received training in how to use this and confidently navigated the system when supporting people to have their medicines. Some medicines used in the home were more specialist and required greater security. We checked the storage and stock of specialist medicines and found the stock balanced with what was recorded in the specialist medicines book. These medicines were locked away securely. All packets and bottles were marked with open and expiry dates which meant that people received medicines that retained the beneficial effects that they were prescribed for and wastage was reduced.

Medicines were stored at the appropriate temperatures. The registered manager agreed to get the recommended temperature ranges added prominently to the medicines fridges so that staff could quickly see if temperatures they were recording were within defined ranges. An air conditioning unit was being used in the medicines room to help keep the room and items stored in it at an appropriate temperature. People were informed what medicines they needed to take and were given a choice as to whether they took them. Spot stock checks of medicines were done daily. These helped to identify when staff needed to order more or to request a review of a person's medicines.

People were supported by staff who had been trained in infection prevention and control and who used personal protective equipment when appropriate. There was an up to date cleaning schedule in place. Cleaning and housekeeping staff told us that they had enough time and equipment to maintain cleanliness. The home was visibly clean throughout and free from malodours. One person said, "It is a very clean place. There is someone always cleaning and polishing." A relative, who visits almost every day, stated, "The home always smells clean and looks clean when I arrive." The home's two sluice room were secure, clean and contained guidance for staff in how to avoid cross contamination. Sluice rooms are where staff dispose of items such as incontinence pads and associated reusable products are cleaned and disinfected.

The home carried out monthly accident and incident audits. This included a description of what had happened and when, the result of the investigation, and follow up action taken. These were then regularly analysed to determine key issues and trends arising from the incident and any learning that could be shared. This had recently helped identify the importance of ensuring that people more at risk of choking when eating were more closely monitored if they were eating when tired and also having a suitable staffing ratio in communal areas to provide reassure to people. Where people had been identified as experiencing a fall, or succession of falls, they were referred to a falls prevention team to reduce the chances of it happening again.

Good

Is the service effective?

Our findings

People had thorough pre-assessments which supported their move to the home. These included information about their background, health needs, skills, preferences and those important to them. People were supported to have choice and had care in line with what they needed and wanted. One person told us, "They remember things very clearly that you've told them. If you say something to them, that's what they'll do. They helped me choose my clothes today." One relative said, "[Name] responds to some of the carers more than me. I'm confident they have the right skills and approach."

People were supported by staff who had received an induction which included shadow shifts with more experienced staff. An ongoing programme of observations by management were carried out to help assess whether staff remained confident and competent in supporting people. These included moving and repositioning and medicines. Staff received training which helped them meet people's specific needs. One staff member said the fire training had helped them manage a recent practice fire evacuation. Another staff member told us challenging behaviour training had enabled them to respond effectively when a person had become agitated and would not let go of their hand. Staff had mandatory training and refresher courses. Topics covered included pressure area care, oral care, and mental capacity. Staff said they felt supported and encouraged to develop. One staff member said, "They are going to support me to do an NVQ after I complete my Care Certificate." Other staff told us, "I worked my way up with the training I was given.", Staff had regular supervision and confirmed that this was used as a time for reflection and development. Records confirmed this.

Nursing staff at the home were aware of their responsibilities to re-validate with their professional body. Registered nurses are required to revalidate their registration with the Nursing and Midwifery Council (NMC). Nurse re-validation is a requirement for all qualified nurses. This process ensures they provide evidence of how they meet their professional responsibilities to practice safely and remain up to date. The registered manager told us they kept records to alert them when nurses were due to complete revalidation. This meant registered nurses working in the home had up to date registration with the NMC. One nurse told us that a senior manager had been very supportive with this process.

People were supported to eat and drink sufficiently. People's dietary needs and preferences were well known and catered for. People with increased risks with their food and drink intake were on safe swallow plans (these detailed the most suitable food textures and consistency of fluids to reduce risk for people with problems swallowing). These plans were available to the kitchen staff who were then able to minimise risks for people in line with recommendations from health professionals. We observed the chef preparing diabetic versions of meals and a kitchen assistant being advised, "Remember [name] doesn't like custard as it reminds them of school." Coloured trays were used to discreetly identify to staff people who required extra support. People who had reduced dexterity were given adapted cutlery. This meant that they could be as independent as possible. The home was in the process of purchasing coloured plates and bowls which are known to make meal times easier for people with dementia. The chef used picture cards for people that needed more help in deciding what they would like to eat and drink.

Each person's food and fluid intake was recorded so that early identification and follow up could happen if it was below recommended levels. Weekly or monthly weight checks were completed to identify if people were at risk of becoming malnourished. Staff followed guidance from health care professionals to monitor people's advised daily fluid intake. We saw evidence that low intake had led staff to contact relevant health professionals.

Food was plentiful, warm and well presented. People had choice in what they had and where they ate it. We observed some people chose to or required support to eat in their bedrooms. The staff were encouraging and patient. We heard one staff member saying, "Here you are love. It looks good" when raising a spoonful of food to a person's mouth." People could have as much or as little as they wanted. Finger foods were available for people to snack outside of typical meal times. We heard a person stating, "It's lovely" when being asked by a staff member about their lunch. One family had written to the home to commend them for the care their relative had received and added, 'special mention to the head chef for excellent food.' A relative told us, "The food is good. I have tried it. There is a good choice."

The home had a good working relationship with the local tissue viability team. A tissue viability nurse, who had known the home for the past seven years, told us, "The care there is better than it has ever been. The home is very pro-active in seeking advice from us. [A recent] referral was very comprehensive. Their photography was very good and they'd attached it to the referral. That meant we were very informed. I have no concerns with the home. I think their documentation is better. [The head of care] accompanies me when I visit and takes notes. Once the staff see something they are doing what we expect them to do. They act quickly." The registered manager told us that since the most recent contract monitoring visit in August 2018 skin care guidance in people's care plans was more person centred and prescriptive.

People also benefited from staff arranging appointments with health professionals such as dieticians, dentists and occupational therapists. Outcomes for people were then shared with staff during handovers. The home received weekly visits from a local GP. The GP said that the staff were good at recording changes in people's needs and informing them of these in a timely way including where urgent follow up was required. The GP added that the staff were "very good at following instructions" and they had "no concerns" with the care people receive there. One relative said, "[Name] is seem by the GP that visits the home and [name] also has [their] own GP if needed." The links that the home had established with these health professionals helped to keep people well for longer and reduced the need for admission to hospital. The home had prepared hospital packs for each person that could support successful transition into hospital if required. These included people's communication needs, network of support, risks and mental capacity.

People lived in a home that was well maintained throughout and decorated in a way that made it feel and look homely. The home had a full-time maintenance person. Lighting in the home was set at a level recommended by a university that does research into comfort for older people and those with dementia. Accommodation was provided across two floors. There was a passenger lift to the first floor. The home also had a platform lift that enabled people using wheelchairs to access the communal dining room. Doors to bathrooms and toilets were coloured in a way that communicated their use to people with dementia. Additional signage around the home clearly defined each room's purpose. There was an outside courtyard with covered seating area, BBQ, pond and raised planters. Some people accessed this area using the patio doors from their rooms.

People expressed satisfaction with their rooms and told us they had been supported to personalise them according to their tastes. One person said, "I'm quite happy with my room." This person had been supported to put up examples of crafting that they had done. This helped them and others to recognise and celebrate the skills and abilities that they had. Other people expressed, "I'm very happy here. My room is lovely", "I

think my room is very nice", and "I like my room. It's spacious."

Staff had received training in mental capacity and dementia care. As a result, people were supported by staff who understood the principles of the Mental Capacity Act 2005 and how it applied to the people there. Staff could confidently tell us how they sought consent and worked in people's best interests. We observed staff consistently asking for people's consent prior to supporting them. One person told us, "[They] always ask for my consent when they need to do things for me."

Staff could tell us when and who they would involve if a person lacked capacity. 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. Where people were assessed as lacking capacity to make an informed decision on a particular issue best interest decisions had been made with relatives, staff and health professionals. Meetings had been held to discuss best interests around things such as bed rails, photographs for body maps, and medicines. On these occasions the home had included people's relatives and/or those with the legal authority to make decisions on their behalf, such as power of attorneys or deputies, and health and social care professionals.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The home had applied for DoLS for each person that required this. The home kept a record of when DoLS applications had been sent to the local authority. Some of the DoLS had been granted and others were awaiting authorisation. The registered manager had evidence to show that they had followed up delays in DoLS being authorised and agreed that this information would be added to their DoLS record. For three people that had specific conditions attached to their DoLS, we saw that staff were meeting these.

Good

Is the service caring?

Our findings

People were supported by staff who were consistently kind, caring and patient in their approach. We observed staff speaking with affection when interacting with people. This demonstrated respect and the rapport that they had built with them. One person told us, "The staff are wonderful and very attentive. Some come to say goodbye after finishing their shift. I've made a lot of friends with the staff." One relative said, "The staff are very good. They speak to [name] better than I do. They are kind and talk to [name] as a human being."

People's privacy and dignity were considered and supported. Staff knocked on people's doors and sought permission before entering their rooms. People told us that if they did not want anybody in their room staff would respect their wishes and come back later. When people needed support to move using specialist equipment the staff put screens around them to maintain their dignity. Two people said, "The staff treat me with respect and look after my dignity at all times" and "The staff always protect my dignity." Continence products were stored discreetly.

Staff understood the importance of ensuring that no personal information was on display in people's rooms. We only observed one example of this and when raised with the registered manager it was discovered that this had been put up by a relative to support the staff. The registered manager discussed this with the person's relative and it was agreed to keep the guidance more discreetly in a draw. This helped maintain the person's privacy.

People told us that they could live their lives how they chose to and their independence was supported. For example, people were given the option of engaging with activities, having time to themselves, or spending time with those important to them. One staff member was heard saying to a person, "Are you not coming downstairs today? Having a quiet one are you?" One person told us, "Nothing stops me coming to bed anytime I choose." Nobody at the home was known to be in an intimate relationship. The registered manager said that if a person came to stay that was in a relationship, or decided to start one while there, they would support them. They said they would do this by seeking health professional guidance and, if required, request a mental capacity assessment to determine what support they may require to maintain the relationship and stay safe.

Good

Is the service responsive?

Our findings

People were supported by staff who involved them and their relatives in developing a care plan to meet their needs and reviews when these changed. One person said, "They do go through my care plan with me and ask if it is all okay with me." Two relatives told us, "There is a care review every year and I can bring up any matter I am concerned with" and, "I am involved with my [family member's] care plan. They involve me all the time."

Staff treated people as individuals and interacted with them in a way that showed they were receptive to, and guided by, their needs and wishes. For example, one staff member was heard asking a person who they were supporting to move in bed, "[Name] do you want me to put your head down a bit? Are you alright? Say when. Is that alright for you?" People had memory boxes outside their rooms which contained objects and information celebrating what was important to them and what they had achieved so far in their lives. Some of these were more developed than others. The home had used the September 2018 newsletter to encourage relatives and friends to help improve these so that they 'expressed [the person's] life before Weymouth Care Home.'

The home understood the importance of establishing and maintaining a sense of community between people living at the home, their relatives and the staff. The home put together a monthly newsletter for people and their relatives. This was delivered to people's rooms. Staff provided support to read and understand the content where people required this. The newsletter helped to generate and sustain a sense of community. The September 2018 edition included a celebration of previous events, advised people of approaching birthdays, detailed new staff, and upcoming activities.

People had access to an activities programme which included regular visits from singers, musicians and exercise groups. The home was doing the necessary recruitment checks for a driver for the home's minibus to support trips out after the recent passing of their long-standing and much-loved, volunteer driver. A newly appointed part time activities coordinator had started consulting with people, relatives and staff to help ensure that each person's needs and preferences were being met. This staff member had supported people to go shopping using the local low-level buses which were wheelchair accessible.

Activities were well publicised and delivered in communal areas and via 1:1 sessions in people's bedrooms. Staff were observed offering people on both floors the opportunity to join in with group activities in the main lounge. One relative told us that there were "plenty of things on" while adding, "They have a lovely lady who comes to sing. She is so good you would pay to see her." A visiting singer entertained people after lunch on day two of the inspection. This was well attended with people smiling, singing, and dancing in their chairs. People told us that they had enjoyed this and that the singer was a regular booking. One person said, "I enjoy the activities here. They are very good."

Records showed that people who preferred or whose health meant that they spent more time in their rooms were offered 1:1 sessions including nail painting, hand massage with aromatherapy oils, and poetry. This was helping to reduce the risk that they would become socially isolated. The registered manager said that,

with another part time activities coordinator due to start, and the home looking to secure two activity volunteers, they planned to further improve the quality and variety of activities that people can enjoy. The part time activities coordinator had links with a local church, performing arts department and a pet therapy group and planned to draw on these community resources in developing the group and 1:1 activities programme at the home.

People were supported to maintain contact with those important to them. One person told us, "I have a lot of visitors. They can come freely." We observed people being visited by relatives some of whom visited every day. One relative said the registered manager had allowed their family to use the home's library to host a birthday party for their family member and that the chef had even surprised them with a cake. We observed people being supported to speak to friends and relatives by phone or doing this independently where they were able to. One person said they were "happy" and smiled when we reminded them of a telephone conversation they had been supported with on day one of the inspection. The registered manager said, "There is nothing more rewarding than enabling someone to do something that's important to them."

People had the opportunity to follow their faith with two services offered each month. The registered manager told us that they were planning to introduce rotating services from different denominations so that more people had the opportunity to attend a service connected to their faith.

People and relatives said that they felt listened to and were confident that anything they raised would be resolved. Records showed that complaints were acknowledged, tracked and resolved in line with the provider's complaints policy, a copy of which was on display in reception. There had been no complaints since March 2018. One relative said, "I do know how to bring up a concern. I would start with a nurse and escalate up to the manager.' Another relative said, "I have raised concerns and they have been resolved quickly." One relative said they had asked for a female carer rather than a male carer to support their family member. The relative said this had been done immediately and this had helped their family member feel more settled.

The home met the requirements of the Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's communication needs were clearly assessed and detailed in their care plans. This captured the persons preferred methods of communication and how best to communicate with them. When one person's communication had been impacted by a health condition staff had used communication cards to interact with this person. Staff helped people to know what day and time it was by making sure their calendars were on the correct month and their clocks or watches showed the right time. This meant people could plan their day more easily and prepare for upcoming appointments and activities.

Staff had been trained to support people at the end of their life. The home had also established links with specialist nurses from a local hospice. Two families had fedback in cards which said, 'Heartfelt thanks for the dedicated and loving way you cared for [name] until the end' and, 'To all at [the home] who made [name's] last 18 months the best they could possibly be. With love and thanks.'

Good

Is the service well-led?

Our findings

Staff members told us they enjoyed working at the home. Their comments included: "I love working here. I get on with the rest of the team. I'm proud of them. We all pull together', 'These staff are good to work with", "We all get on well and work together as a team" and, "We have staff get togethers outside of work." Three people's comments confirmed what the staff had told us when they expressed, "I haven't come across any staff who don't like it here", "The staff are happy and they laugh a lot" and, "There is a good atmosphere here all the time." We observed positive and friendly interactions across all levels of the staff team. There was an open-door policy with the registered manager seen as approachable by staff. Notes from a senior meeting noted that the registered manager had advised staff that her 'door was always open if anyone needs anything.'

The registered manager had a robust knowledge of the type of incidents or events they needed to notify CQC about including events that require police involvement, incidents resulting in injury, and alleged abuse. People and relatives expressed confidence in the leadership provided by the registered manager. Relative comments included, "The care home is well managed" and "The home is well run here." Two people expressed, "I have met the manager. She is very nice" and, "[The registered manager] is very nice and helpful. I think the home is well run."

The staff had regular team meetings with these used to discuss and reflect on areas such as: effective use of pressure relieving equipment, team work and home security. Records showed these meetings were well attended and were scheduled in a way that meant both night and day staff were included. This helped to build a cohesive team. Staff handover meetings were held at 8am and 8pm each day. We observed an 8am handover. It was well attended, key information was shared which matched what we had seen, heard and read in records, and staff spoke freely and with confidence.

Staff told us that they received praise and were made to feel valued by their colleagues and management. Records showed that good practice was recognised. One person's appraisal stated, '[Name] is an asset to the team and is always willing to help others.' The recent newsletter celebrated an employee of the month and noted a tea party had been held to mark another staff member's five years at the home. Two staff told us, "It's good here. It's rewarding", and "[The registered manager] is a really good manager. She is concerned about us and checks if we are okay." Where issues were found with staff members' practice or approach responsive supervision meetings were held to support the staff member to reflect and improve.

The registered manager received support from the operations manager who visits the home on a weekly basis. The registered manager said support for them also came from the provider's HR and training departments and through linking with other registered managers at sister homes. Networking opportunities were available through membership of a local care home forum.

Due to the increasingly complex needs of people at the home it was felt that a residents meeting was not the best way of getting their views. Instead the registered manager planned to undertake individual discussions with people and/or their relatives to get their views. Annual surveys were conducted with the most recent

one completed in March 2018. Results from the survey had been analysed and an action plan put together to resolve any issues raised. Even where a respondent's feedback was negative in comparison to all other respondents' feedback this was followed up. This demonstrated how the home saw each person's views as important.

Quality monitoring systems and processes were in place and up to date. These systems were robust, effective, regularly monitored and ensured improvement actions were taken promptly. Audits focused on areas such as complaints, pressure relieving equipment, and care plans. The home used the audits to determine what they did well and where improvements were needed. For example, this had led to improved care planning with people's plans now more reflective of their individual needs.

The home had established collaborative partnerships with other agencies including a tissue viability nursing team, nurses from a local hospice and a dietician. This approach helped ensure that staff had expert and up to date advice available to help them identify, understand and meet people's current and emerging needs.