Friends of the Elderly

Moor House Residential Care Home

Inspection report

Vicarage Road, Staines, Middlesex
TW18 4YG
Tel: 01784 453749
Website: www.fote.org.uk

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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

Overall summary

The inspection of Moor House Residential Care Home took place on 18 and 19 March 2015 and was unannounced. 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 and to look at the overall quality of the service. The previous inspection was carried out on 21 February 2014 and found that the provider had met the standards required.

Moor House is a residential care home and provides care and support for up to 25 people, some whom are living with brain impairment, dementia or mobility issues. At the time of our visit there were 20 people living at Moor House. People who live at Moor House have their own rooms and access to a variety of communal facilities such as the lounge, dining room, and a library/computer room. There is a passenger lift available to allow access to the upper floor, and spacious gardens for the enjoyment of residents.

Summary of findings

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

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs. However there were insufficient staff deployed at night which had an impact on the care provided. People told us they felt were safe at the home, one person told us, "I have been very safe here." Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from harm.

Recruitment practices were safe and relevant checks had been completed before staff commenced work. Staff worked within good practice guidelines to ensure people's care, treatment and support promoted a good quality of life. Medicines were managed safely. Any changes to people's medicines were prescribed by the person's GP.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and were involved in the regular monitoring of their health. The home worked effectively with healthcare professionals and was proactive in referring people for treatment.

Staff involved and treated people with compassion, kindness, dignity and respect. People told us, "The staff are very friendly and kind." "They are nice girls and hardworking." People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit. People's privacy and dignity were respected and promoted. Staff told us they always made sure they respected people's privacy and dignity when providing personal care. The home was organised to meet people's changing needs. People's needs were assessed when they entered the home and on a continuous basis.

People told us if they had any issues they would speak to the staff or the registered manager. A person told us, "I've never complained, but would if something was not right." People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service provision.

People had access to activities that were important and relevant to them. People were protected from social isolation with the activities, interests and hobbies they were involved with. Staff supported people with their interests and religious beliefs in their local community. Religious services were conducted weekly at the home.

The provider actively sought, encouraged and supported people's involvement in the improvement of the service. People's care and welfare was monitored regularly to make sure their needs were met within a safe environment. The provider had systems in place to regularly assess and monitor the quality of the service provided. Management obtained guidance and best practice techniques from external agencies and professional bodies.

People told us the staff were friendly and management were always visible and approachable. Staff were encouraged to contribute to the improvement of the service. Staff told us they would report any concerns to their manager. Staff told us the manager of the home was very good and very supportive; some of the staff stated that at difficult times, such as when people's behaviour was challenging or when people were receiving end of life care, they did not always get the support they needed.

Summary of findings

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 consistently safe.

There was a consistent staff team that people knew and they supported the delivery of consistent care during the day but there were insufficient staff deployed at night to provide consistent safe care.

People were protected from abuse and avoidable harm by effective recruitment procedures and staff who were trained to work within current guidance.

People had risk assessments based on their individual care and support needs.

Medicines were administered and stored safely.

Is the service effective?

Good

The service was effective.

People's care, treatment and support promoted well-being based on best practice guidance.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk.

People were supported to have access to healthcare services and were involved in the regular monitoring of their health. The service worked effectively with healthcare professionals and was pro-active in referring people for treatment.

Is the service caring?

Good

The service was caring.

Staff involved and treated people with compassion, kindness, dignity and respect.

Interactions between staff and people who used the service were kind and respectful. Staff were happy, cheerful and caring towards people.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit.

People's privacy and dignity were respected and promoted. Staff told us they respected people's privacy and dignity when providing personal care.

Summary of findings

Is the service responsive?

Good

The service was responsive.

The service was organised to meet people's changing needs.

People's needs were assessed when they entered the service and on a continuous basis. Information regarding people's treatment, care and support was regularly reviewed.

People had access to activities or interests that were important to them and were protected from social isolation through the range of activities available within the home and community.

People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard.

Is the service well-led?

Good

The service was well led.

Some of the staff stated that at difficult times, such as when people's behaviour was challenging or when people were receiving end of life care, they did not always get the support they needed. Others stated that they did receive support.

The provider actively sought, encouraged and supported people's involvement in the improvement of the service.

People who used the service told us the staff were friendly, supportive and management were always visible and approachable.

Staff were encouraged to contribute to the improvement of the service and could report any concerns to their manager who was very supportive.

Moor House Residential 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 18 and 19 March 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. Our expert-by-experience was a person who has personal experience of caring for someone who uses this type of care service.

Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We also reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete 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. This was because we were carrying out this inspection in relation to some concerns we had about the home.

During our inspection, we spoke to nine people who lived at the home, five relatives, eight staff, the deputy manager and a local GP to find out about the service. We observed how staff cared for people, and worked together. We observed care and support in communal areas and we looked at some of the bedrooms with people's agreement. We also reviewed records about people's care, support and treatment and the provider's quality assurance and monitoring systems.

Requires improvement

Is the service safe?

Our findings

People had mixed comments about the number of staff on duty, comments made were**,** "Yes, I think there is enough staff, there is always someone around", "There is enough staff during the day but not sure at night" and "They could do with an extra one staff member at night."

We found the staff team was qualified, skilled and experienced to support people's care needs, however the number of staff on duty had an impact on the level of support given as staff were busy attending to other people's needs. There was insufficient staff on duty at night which had an impact on the level of care which could be given. The deputy manager informed us that there were two members of staff on duty at night and one of these was responsible for administering medicines. We were told this staff member should not be disturbed when performing this task, this meant that there was only one member of staff to take care of 20 people, some of whom had complex needs, or needed more than one member of staff to support them. For example, a person had to wait a long time for assistance with personal care. The home also provided end of life care which required additional support from staff. Staff told us that recent changes in people's needs had placed pressure on the staff team. Some staff told us that they did not have the necessary support during these times, but others stated that managers had supported care staff by doing some of the tasks usually carried out by care staff. We reviewed staff rotas covering the last three months and there was no change from the allocation of two members of staff on duty at night, even though there had been an increase with regards to people's needs. This demonstrated that the staffing levels had not changed in line with people's increasing needs.

There was a staff recruitment and selection policy in place and followed. All applicants completed an application form which recorded their employment and training history. The provider ensured that the relevant checks were carried out as stated in the regulations to ensure staff were suitable to work with adults at risk. We saw from the records that staff were not allowed to commence employment until satisfactory disclosure and barring checks and references had been received. All new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

People told us they felt safe at the home, comments made were, "I've felt very safe, the staff are excellent", "I have felt safe, I've never had any abuse." We noted that information about abuse was discussed at residents' and relatives' meetings and people were provided with ways to report any form of abuse.

The service had the most recent Surrey County Council (SCC) multi agency safeguarding policy. SCC is the lead agency for all matters relating to adult safeguarding in Surrey. This provided staff with guidance about what to do in the event of suspected abuse. Staff confirmed that they had received safeguarding training within the last year. Staff knew how to report concerns if they witnessed abuse or poor practice and told us they would feel confident in doing so if necessary. A member of staff told us, "I would always report it to the manager." Staff said that safeguarding was discussed regularly at team meetings and that managers reminded staff of their responsibilities in this area.

Policies were in place providing clear guidance to staff about how to protect people and staff from harassment. This contained information about the definition of harassment and what action to take in different situations. Policies also covered how to protect people's human rights, including the risks and usage of restraints of older people.

We saw there were arrangements in place to store people's money safely and to reduce the risk of financial abuse. Each person had their own separate wallet to store their money, any monies paid in or out were itemised and the balance remaining was recorded and signed for. Copies of expenditures were available to individuals and their relatives and all monies were stored securely.

People were involved in their risk assessments and any healthcare issues that arose were discussed with the involvement of a health care professional such as GP or community nurse. Staff were knowledgeable about people's needs, and how to care for people who were distressed or at risk of harm. Risk assessments clearly detailed the support needs, views, wishes, likes, dislikes and routines of people. Risk assessments and protocols identified the level of concern, risks and how to manage the risks. The information provided enabled care and treatment to be planned in accordance to people's needs.

Fire safety arrangement and risk assessments for the environment were in place to help keep people safe.

Requires improvement

Is the service safe?

The deputy manager showed us their business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding and power cuts. The provider had identified alternative locations which would be utilised if the home was unable to be used. This would minimise the impact to people if emergencies took place.

People told us**,** "I get medication when I expect it.", "They know where my medication is and you can have painkillers if you need to."

We saw that staff had carried out a risk assessment to support people to manage their own medicines safely if they wished and were able to. People were provided with safe storage of their own medicines to prevent the risk of other people taking them. The risk assessment was reviewed each month to ensure that it continued to reflect the person's needs accurately. However there was no formal arrangement in place to record how often they should check people who self-medicate medicines were still safely managing this.

There were written protocols in place for the safe management of medicines. We spoke to the member of staff responsible for the administration of medicines during our inspection and they demonstrated a good awareness of the home's medicines protocols. We observed that the staff member carrying out the medicines round wore a tabard asking not to be disturbed, which enabled them to focus solely on their task and reduce the risk of errors.

Only staff who had attended training in the safe management of medicines were authorised to give medicines. We saw evidence that staff attended regular refresher training in this area. Once they had attended this training, managers observed staff administering medicines to assess their competency before they were authorised to do this without supervision. We saw an example of a competency assessment and noted that it was a thorough test of the staff member's ability to give medicines safely. The deputy manager told us that staff retook their competency assessments every six months.

We checked the arrangements for the storage and recording of medicines. Medicines were stored securely and in appropriate conditions. All medicines coming into the home were recorded and medicines returned for disposal were recorded in a register. A register was also maintained for controlled medicines. Medicines were checked at each handover and these checks were recorded.

We checked medicines records for five people. We found that a medicines profile had been completed for each person and any allergies to medicines recorded. The medicines administration records we checked were accurate and contained no gaps or errors. Any changes to people's medicines were prescribed by the person's GP.

The home was clean and there were no unpleasant odours. One person told us, **"**The laundry is good and the rooms and common areas are clean." There were procedures in place for staff to follow cleaning schedules and record cleaning tasks performed. Staff were in uniform and 'bare below the elbow'. This allows staff to wash their hands more effectively. Staff were also seen wearing personal protective equipment such as gloves and aprons and there was hand wash, paper towels and antibacterial gel available throughout the home to help prevent cross infection.

The registered manager had obtained guidance from external bodies regarding best practices and guidance about contactable diseases to ensure that people were protected from the spread of disease and infection.

Good

Is the service effective?

Our findings

One person said, “When I came I had a bad back, but now that is much better. The staff seem to have time for a chat.” The provider promoted good practice by developing the knowledge and skills staff required to meet people’s needs. A staff training chart showed that all staff had been trained in areas relevant to their role to ensure that people living at the home were supported by trained staff. The training consisted of safeguarding, moving and handling, infection control, medicines management, safe food handling, fire awareness, First Aid, health and safety, dementia and end of life care.

Staff did not have an awareness of their responsibilities regarding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) as they had not attended training in this area. We noted that the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) training was scheduled for October and November 2015. The deputy manager stated that they would contact the training provider and see if they could get an earlier training date.

There were qualified, skilled and experienced staff to meet people's needs. During our observations, we saw two members of staff using equipment to transfer a person with limited mobility from a chair to their wheelchair. The process was carried out sensitively and skilfully to promote people’s dignity. During the process the person was constantly reassured and told what was happening. Conversations with staff and further observation of transfer techniques confirmed that staff had received training and that they had sufficient knowledge to enable them to carry out their role safely and effectively. Staff told us, “We are here to care for and support the residents.”

The registered manager ensured staff had the skills and experience necessary to carry out their responsibilities. There was a recruitment and selection policy in place and was followed. Staff confirmed they had completed application forms which had recorded their education, training and employment histories. Staff confirmed that an induction programme was in place. The deputy manager confirmed that additional shifts would be covered by existing staff or bank staff that are knowledgeable about people and understood their individual needs to ensure consistent care.

Staff told us they had regular meetings with their line manager to discuss their work and performance. There was mixed feedback regarding the support staff received, six staff told us that they received sufficient, whilst two felt they did not. A member of staff told us, “Yes we have supervision and appraisals, but there are times when we don’t always get the support we need.” Staff told us that during difficult times such as end of life care, they would have liked more support. We spoke to the deputy manager who stated that extra staff are provided during end of life care but would look to see what other support might be required. The deputy manager confirmed that supervision took place with staff to discuss issues and development needs. Staff confirmed that they had annual appraisals or were due to have one. We reviewed the provider’s records and noted that staff had received supervision and appraisals.

People had their needs assessed and specific care records had been developed in relation to their individual needs. For example, where people needed assistance with eating or had special dietary requirements, information and guidelines were recorded to ensure their needs were met. Some people required products to be added to their food and drink to enable them to swallow without harm and instructions were given to staff regarding the dosage and consistency required. Where people had mobility needs or were susceptible to falls or injuries, information was recorded to help minimise these. We noted that handrails were placed throughout the home to support people’s independence.

People told us they were able to move around the home without restrictions. One person told us “I have the freedom to move around as I wish. It’s like home.” Another told us, **“**I am able to move around freely.” There were policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005. The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. The basic principle of the act is to make sure people whenever possible are enabled to make decisions and where this is not possible any decisions made on their behalf are made in their best interests. DoLS provide a legal framework to prevent unlawful deprivation and restrictions of liberty. They protect people who lack capacity to consent to care or treatment and need such restrictions to protect

Good

Is the service effective?

them from harm. We noted that a DoLS application had been made regarding a person's safety due to their wandering and anxiety which might lead them to harm when leaving the building unnoticed.

A mental capacity assessment was carried out to determine whether people had capacity to make decisions about everyday issues and more complex decisions. Detailed information about these assessments were found in their care records including who could make these decisions and in what context they could be made. This demonstrated that there were arrangements in place to protect people's rights and the provider acted in accordance with appropriate guidelines.

People told us about the quality of the food at the home, one person told us, "The food's reasonable with choice and portions are reasonable." Another person told us, "The food is normally very good, today it was not." People are involved in the consultation about the choice of menu for breakfast, lunch and tea. One person told us, "If you did not fancy anything, they would do something else for you." There was a choice of nutritious food and drink available throughout the day. The menu had written information to describe the meals on offer but lacked pictures which could help some people make a more informed choice. We feedback the information about the food to the deputy manager who stated they would discuss the matter with the chef. We saw that drinks were available in each person's room and throughout the home that people could access.

People told us that they had complained about the food, one person told us, "I said at a meeting that the quality of the food was poor." Another person told us, "We are looking for plain English food." We saw records that a meeting was held to discuss the issues raised about the food and action was taken.

We saw staff assisting people to prepare for lunch, at their own pace. People who were unable to eat independently were supported by a member of staff in a sensitive way to promote their dignity. Throughout the day people were encouraged to have regular drinks to reduce the risk of dehydration.

People were supported to have their nutrition and hydration needs met. Care records contained information about people's food likes and dislikes and preferences. Staff were aware of those who had special dietary requirements.

We saw that pre assessments were carried out before people moved into the home and then were reviewed once the person had settled into the home. The information recorded included people's personal details, whether people had capacity to make decisions, this was be reviewed on a regular basis as people's capacity could vary from to time, and details of health and social care professionals involved in supporting the person such as doctor and care manager. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs to ensure staff had the most up to date information.

We asked the deputy manager how the service continued to care for people safely when their level of need increased or if they required nursing input. The deputy manager said that the service was well supported by the local community nursing team and that the GP was willing to visit as often as required.

People had access to healthcare professionals such as GP, community nurse, occupational therapist, community psychiatric nurse, diabetes nurse and other health and social care professionals. We saw from records that following any changes to people's needs, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. A visiting healthcare professional told us, "Staff were good at communicating people's needs to us, the level of care is very good, they're very attentive to residents, staff know them, any instructions given to staff are followed through." People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in their care records. This meant staff had clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring. The atmosphere in the home was calm and relaxed during our inspection. One person told us**,** "I think this is a nice place to be." Staff showed kindness to people and interacted with them in a positive and proactive way. Staff spoke with care and compassion about how they had supported people receiving end of life care and their relatives.

A person told us, "The food is better and there are more activities we can take part in if we want to." A relative told us, "They look after my family member well."

The deputy manager told us, "We try to keep it as homely as possible, it is their home."

People were able to make various choices such as whether they would like their door open or closed, so they could maintain their privacy. People told us, "I am able to move around freely" and "You can please yourself about going to bed early and I get a nice cup of tea at 6am." People are able to make choices about when to get up in the morning, what to eat and what to wear, so they could maintain their independence. People were able to personalise their room with their own furniture, personal items and choosing the décor, so that they were surrounded by things that were familiar to them.

People told us "The staff are very pleasant and agreeable", "You can't fault the care" , "You don't hear the staff grumbling about anything" and "They are nice girls and hardworking." Relatives had mixed comments, they told us "The care here is brilliant" and "The care varies from well looked after to hurried." The staff had also catered for couples, and provided them with two rooms to ensure that they could have privacy and space.

Staff knew about the people they supported. They were able to talk about people and their life, their likes, dislikes, interests and the care and support they needed. We saw detailed information in care records that highlighted people's personal preferences, so that staff would know what people needed from them. Staff knew people's religious, personal and social needs and preferences from reading their care records and getting to know them. We noted that care records were reviewed on a monthly basis or when care needs changed. For example, staff are to tell X to use her frame when they see her without it as she is susceptible to be falls, or a person has a routine they like to follow when having personal care.

People were involved in making decisions about their care. We observed that when staff asked people questions, they were given time to respond. For example, when being offered drinks, or choice of meal. Staff did not rush people for a response, nor did they make the choice for the person. Relatives confirmed their involvement in their family member's care planning, and there was detailed information recorded of best interest decisions made for those who lacked capacity. Staff were knowledgeable about how to support each person in ways that were right for them and how they were involved in their care. For example there are people, whose behaviour is challenging so to ensure they are supported they required the assistance of two members of staff.

People told us, "The staff seem to have time for a chat" and "They are very good with residents who are challenging." People felt staff treated them with dignity and respect. We saw staff take time when supporting people and explaining how they could assist people and asking if the person was happy with this. We heard staff call people by their preferred names.

People told us that staff treated them with kindness and compassion. One person said "They are always extremely nice to me and I think to others as well." We saw that staff treated people with dignity and respect. Staff explained to people when they were going to assist them, such as moving them with lifting equipment. At each stage they checked that the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner.

People's relatives and friends were encouraged to visit and maintain relationships. People confirmed that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres and people from the religious community visited the home. People had access to a computer where they could access the internet and use it to contact family and friends.

People told us**,** "They definitely treat me with respect and close my door", and "They respect my privacy, they are always in and out and always knock and shut my door when they are attending to me."

Good

Is the service caring?

People could be confident that their personal details were protected by staff. There was a confidentiality policy in place. Care records and other confidential information about people were kept in a secured office.

People were supported to express their views about their care, support, treatment or the service in different ways such as: day to day conversations with staff, 'resident' meetings and at parties. We saw minutes of the 'resident' meetings which recorded people's feedback about activities, care provided and the menu. We noted that there has been a lot of feedback about the menu, residents has asked for a variety of vegetables and a choice of puddings to be added as there was far too many of one particular choice. We noted from the menu that these changes and more had been made. Minutes of a meeting held in March 2015 had reflected the improvements made.

A visiting healthcare professional told us "The end of life care is very good, everyone is involved, GP, palliative care, if they [staff] need more help they will ask for it.", "I have never seen a resident's care compromised." Information about how to support and provided comfortable and, dignified care whilst receiving end of life care was documented in their care plan. Information about how to support people's wishes after their death had also been recorded. We noted that people's relatives were able to visit anytime and that people were not left alone to die. The staff we talked to spoke with care and compassion about how they had supported people receiving end of life care and their relatives.

Good

Is the service responsive?

Our findings

People told us they were happy with the support they received comments made were, "I'm quite happy here, I get the care I need" and "I don't get bored here, there is always something going on", "I join in some things, there's enough variety" and "I do get the care I need, especially when I'm not well."

The care records had detailed information which identified individual's care and support and any changes to people's care was updated in their care record, this ensured that staff had up to date information in regards to people's care needs. The deputy manager confirmed that they involved people, health care professionals and relatives in the decisions and planning of care.

People told us, "When I have used my alarm (call bell), the response has been very quick." Care given was based on an individual's needs, care and treatment. For people whose behaviour may be challenging, guidance was provided to staff to minimise risk, whilst ensuring people were safe. Staff were quick to respond to people's needs. For people who had mobility needs, guidance was given to staff about how to stop pressure sores developing. The deputy manager told us by having a consistent staff team they were able to build up a rapport with people and that people were cared for by staff they knew and who understood their needs. She informed us that only in extreme cases of short staffing would they use agency staff, otherwise they used bank staff or existing staff would cover annual and sick leave.

We noted that information about the day, date month, season, year and weather was on display. Some of this information was in pictorial format which enabled people to easily identify the information provided. The people responsible for this task told us they enjoyed doing this. Information about an advocacy service was also displayed, so that people could obtain support from an independent person. Information was provided about people's preferences regarding their personal hygiene.

We saw there was a call bell system in place; the system was easy to use. We saw that the information displayed on the call unit indicated in which room the call button had been activated. We observed there were call bells in communal areas as well as in people's bedrooms. People were also able to have a call pendant placed around their neck, so they could summon assistance when required. People told us, "They do respond quite quickly most of the time."

Relatives of a person asked if the flooring in their family member's room could be changed due to their relative's needs, which the provider acted upon.

The home was kept in good decorative order. All bedrooms were clean and decorated to accommodate people's choice. There was a library for people where they could access the intranet; there was a small lounge for people to have some quiet time, a coffee room where people could congregate when they were having their hair or manicures done. There was also a main lounge where most of the activities took place and separate dining room. There were fresh flowers throughout the home.

People were provided with the necessary equipment to assist with their care and support needs. We saw items such as lifting equipment, wheelchairs, bath seats, specialist mattresses and beds, which were used in accordance to people's care needs and support.

People confirmed that they took part in the activities in the home, such as games, arts and crafts and reminiscence sessions. People told us, "I do like to take part in the activities, when I can, and they have asked me what I like to do" Relative told us, "The home organised a buddy from an external organisation for my family member." We observed activities such as hang man (word game), and happy hour as well as people requesting manicures throughout the day. Staff were very good at engaging people in these activities, other people who were not interested in participating read the newspaper, completed a crossword or watched television. We also noted an owner and their dog visited the home and engaged with people, which people enjoyed. People also confirmed that friends and relatives visited them at the home.

Each year the home organised a fete, open day and a garden party. Some of the equipment used during the activities was designed to meet people's needs, such as the bingo machine which displayed numbers so those who had a hearing impairment, could read the number instead. People, who did not want to take part in the group activities, could use the separate lounge where they could do jigsaw puzzles, play games or read a book. Those who were bed bound were offered one to one time with the

Good

Is the service responsive?

activities co-ordinator. There was an activities programme which was displayed throughout the home and each resident received a copy The activity programme was in pictorial form which supported the needs of people using the service to identify relevant activities they were interested in.

People were made aware of the complaints system. People's comments were, "I have only complained about the food" and "I've never complained, but would because the management encourages you to." We noted that a meeting took place in January 2015 and action taken was recorded. There was various ways that someone could voice their opinion about the service. For example entry in a complaints book, completing a form and place in the boxes situated around the home or discuss issues with the manager. People had their comments and complaints listened to and acted upon. We looked at the provider's complaints policy and procedure. The complaints policy gave staff clear instructions about how to respond to someone making a complaint and how the provider would deal with any issues arising from the complaint. For example, we saw that as people had complained about the quality of the food, the head chef held a meeting with residents to discuss their concerns and amended the menu.

The staff told us that they were aware of the complaints policy and procedure as well as the whistle blowing policy. Staff we spoke with knew what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously. The service maintained a complaints log and these were dealt with in a timely manner. We saw information about the complaint procedure displayed in the home, which provided people with the information about the process, contact details for the registered provider, CQC, County Council Adult social care and Local Government Ombudsman.

Good

Is the service well-led?

Our findings

People told us that the manager was approachable, "I have had a lot of dealings with the manager" and "She has an open culture, I can talk to her" "I can approach the manager; I will say what I feel." Relatives told us, "We always see the manager about the place" and "The manager is approachable."

There was an open door policy as we saw people come into the office to share information about their activities, where they were going out or if they required assistance. The managers of the service promoted an open culture.

People told us "There are resident's monthly meetings" and "Relatives can be at our meetings as well." People were involved in how the service was run in a number of ways. We noted that there were 'residents' and relatives meetings for people to provide feedback about the service. We saw minutes of the meeting where people discussed issues regarding catering, health and safety, staff levels, safeguarding, complaints and care provided.

People told us, "It is managed well, and "The teamwork is very good here."

Staff told us that managers were open and approachable and that they could discuss any issues they had with them. Staff told us that team meetings were held regularly and that they could raise any concerns they had at these meetings. Staff told us that they met their managers on a one-to-one basis for supervision and that notes of these sessions were recorded. Staff told us "I do enjoy working here and I feel supported." Some of the staff stated that at difficult times, such as when people's behaviour may be challenging or when people were receiving end of life care, they did not always get the support they needed. The staff did not receive counselling or emotional support when they were caring for people at the end of their life. The deputy manager told us that additional staff were added to the rota when end of life care was given, however she would talk to the staff about additional support needed.

A visiting healthcare professional told us, "The care is fantastic, I trust their decisions and they trust me." People told us, "They make you feel that you can go to them with any problem", "There is a culture of listening and trying to do something about things".

People's care and welfare was monitored regularly to make sure their needs were met within a safe environment. There were a number of systems in place to make sure the service assessed and monitored its delivery of care. We saw there were various audits carried out such as care plans, medicine administration records, health and safety, room maintenance and housekeeping. We saw accident records were kept which contained a description of the accident, time it occurred and if people required hospital treatment. Each accident had an accident form completed, which included immediate action taken, injury evaluation, follow up investigation and action taken such as change mattress and lower bed, check progress throughout the night or referral to healthcare professional. Management observed staff in practice and any observations were discussed with staff. We noted that fire, electrical and safety equipment was inspected on a regular basis.

The provider obtained external guidance from professional bodies such as Environmental Health, and the National Patient Safety Agency to ensure that they had current and relevant information and guidance about best practice techniques with regards to infection control and prevention.

The provider had a system to manage and report incidents and safeguarding. Members of staff told us they would report concerns to the registered manager or deputy. We saw incidents had been raised and dealt with and notifications had been received by the Commission. Incidents were reviewed which enabled staff to take immediate action to minimise or prevent further incidents

The home commissioned end of life care using the Gold Standard Framework and had been accredited. The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling staff to provide a high standard of care for people nearing the end of their life.

We looked at a number of policies and procedures such as environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing. The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated that they were knowledgeable about aspects of this guidance. This ensured that people continued to receive care, treatment and support safely.