Porthaven Care Homes No 2 Limited

Tonbridge House Care Home

Inspection report

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Date of inspection visit:
17 October 2018

Date of publication:
29 November 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We held an unannounced comprehensive inspection at Tonbridge House Care Home on 17 October 2018. Tonbridge House is a 'Nursing home' for people with dementia and accommodates up to 63 people in one purpose built new building. The care is provided over two floors. The upper floor catered for people with more advanced dementia and the lower floor for people with more nursing needs. All bedrooms had en-suite bathrooms and people had access to a luxury bathroom on each floor. There was a nursing station positioned in the middle of each floor. Each floor had their own dining room and lounge. There was also a private dining room which could be booked by people and their relatives, a hairdressing salon and an activities room. On the day of our inspection 24 people were living at the home, seven of which were upstairs.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This is the first time the home has been inspected since it registered on 29 May 2018. 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 and relatives told us they had no concerns with their safety and could speak to the registered manager if they did. Safeguarding and whistleblowing policies were in place and the provider had notified us of any concerns. Risks to people were assessed on an individual basis and there was comprehensive guidance for staff. There were enough suitably trained and safely recruited staff to meet people's needs. The registered manager had ensured the environment was safe and staff understood how to prevent and control infection. The property was well maintained and cleaned to a high standard. The registered manager had an overview of accidents and incidents, had analysed these through their electronic system and learnt from these.

Medicines, including those 'as required' were ordered and given safely through an electronic system. Medication was stored safely, stock levels were managed and discarded medication was disposed of appropriately. There was one incident of a liquid medication where an incorrect expiry date had been recorded and it had been given after it should have been discarded. We spoke to the registered manager about this who took immediate corrective action and the pharmacy advised there would be no adverse effect to the person.

People had assessments which were person centred, included all their needs and their rights to equality. The provider ensured managers, nurses and care staff had the right induction, training and on-going support to do their job. People were supported to eat and drink enough to maintain a balanced diet. People

had the involvement of a dietician and there was information in the kitchen regarding people's dietary needs. Feedback on the food was very positive and we observed people were enjoying the mealtime experience. People were offered choice and were encouraged to have as much as they wanted to eat and drink.

People accessed the healthcare they needed and the provider worked closely with other health professionals to ensure people were supported with various health conditions. People's needs were met by accessible facilities and the environment had been tailored to maintain the independence and dignity of people with dementia. 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.

Staff knew people well and interacted with people in a caring and respectful manner. Medication was administered kindly and nurses offered people any explanations they required. People were involved in their day to day care and developing their care plans as much as possible where they wished to. People's rights to a family life were respected. Relatives told us they could visit whenever they wanted and were made to feel welcome. Some relatives visited every day. Peoples' privacy and dignity was respected by staff and people's independence was promoted.

People's care plans were person centred, had been reviewed regularly and updated when people's needs changed or more information was learnt about the person. Some care plans were work in progress as the home was new and people had only been there for a few months, a few weeks or days. People were receiving care which met their individual needs and effective outcomes were achieved from assessments. People's care plans included a section on communication to detail their individual needs. People were supported to take part in activities they liked within and outside of the home.

People and relatives could raise any concerns or complaints they had and told us who they would talk to. The complaints procedure was available and the provider actively sought feedback from people and their relatives. Complaints were recorded, monitored and managed appropriately. There was an advanced care plan in place for one person described as end of life.

Relatives told us they thought the home was well managed. The management team consisted of the registered manager, the residential care manager, the deputy manager, the client services manager, nurses and team leaders. The registered manager and provider promoted a positive, person centred and professional culture, had good oversight of the quality and safety of the home, and risks were clearly understood and managed. The provider supported good governance through using a system which alerted the registered manager to any incidents. Internal audits were completed, used to check compliance and produce action plans. Record keeping was good and was made easily accessible for staff. The registered manager demonstrated continuous learning by reviewing audit action plans, complaints, promoting feedback and analysing accidents and incidents. Action was taken where needed as a result of the analysis.

Staff told us they were supported by the management team and were encouraged to complete further training. Good communication and staff engagement was promoted. Surveys had been done with staff and were being developed for people and relatives. Meetings were held and the management team were receptive to feedback. The management team worked in partnership with other agencies and engaged with their local community.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Systems and processes were in place to protect people from abuse and avoidable harm.

Risks to people were assessed and there was guidance for staff on how to manage the risks.

People's medicines were ordered, stored, given and managed safely.

There were sufficient, safely recruited and suitable staff available to keep people safe and meet their needs.

People were protected from the risk of infection and were cared for in a clean environment.

The management team learnt from incidents and accidents and made improvements as a result.

Is the service effective?

Good

The service was effective.

Assessed needs were reflected in people's care plans and kept up to date.

Nurses and care staff had received the right training and regular supervision.

People were supported to eat and drink enough to maintain a balanced diet and feedback on the food was very positive.

People were supported to access healthcare services and staff worked with other agencies to ensure people received the health care they needed.

The home had been purpose built to meet people's needs around their mobility and dementia.

Consent to care was sought and people were supported in the

least restrictive way possible.

Is the service caring?

Good

The service was caring.

Staff knew the people they cared for well and treated people with kindness and respect.

People were informed and involved in their day to day care.

Staff respected and promoted people's needs for independence, privacy and dignity.

Relatives and friends could visit when they wished and were made to feel welcome.

Is the service responsive?

Good

The service was responsive.

People's care plans described the support they needed and were person centred.

People were supported to take part in activities they liked.

People and relatives told us they knew how to make a complaint and thought they would be listened to.

People were supported at the end of their life in line with their wishes.

Is the service well-led?

Good

The service was well-led.

The management team promoted a positive culture and had a clear vision to provide high quality care.

Quality, performance and risks were well managed and there was a culture of continuous learning and improvement.

People and relatives were engaged with the home and feedback was all positive.

Staffs were supported, invited to offer feedback and engaged with the home.

The provider was building up community partnerships and

worked with other agencies.

Tonbridge House 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 is the first time the home has been inspected since it registered on 29 May 2018. The inspection was prompted in part by two anonymous complaints we had received from the general public. The information shared with CQC indicated potential concerns about the safety of people and a negative staff and management culture at the home. We took this into account when we inspected the home and made the judgements in this report. Following this inspection, we received two further anonymous complaints of a similar nature. However, we did not find any evidence which supported any of the complaints made either during our inspection or within subsequent conversations with the provider and registered manger.

This inspection took place on 17 October 2018 and was unannounced. The inspection team consisted of three inspectors and a specialist advisor. Before our inspection we reviewed the information we held about the provider including the registration report. We looked at notifications which had been submitted to inform our inspection. A notification is information about important events which the provider is required to tell us about by law.

The provider had not completed a Provider Information Return as we had not asked them to since they were newly registered. 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 met people who lived at Tonbridge House and observed their care within communal areas. We looked at the interactions between staff and people. We spoke to five people and three relatives who visited. We inspected the environment, including the laundry, kitchen, dining rooms, lounges, bathrooms and some

bedrooms. During the inspection we spoke to three care staff, two nurses, the registered manager, the deputy manager, the home trainer, the client services manager and the leisure and wellness co-ordinator. We displayed posters in the reception area inviting feedback from people, relatives and staff. Following this inspection we invited feedback from three healthcare professionals but did not receive any. We reviewed seven people's care records. We looked at medicines records. We reviewed four staff recruitment files, staff induction, training and supervision records and a variety of records relating to the management of the home including staff rotas, complaints records, accidents and incidents records and quality audits.

Good

Is the service safe?

Our findings

People told us they had no concerns with their safety and could speak to the registered manager if they did. One relative who visits their loved one every day told us they have never been worried and if there were, they would speak to the manager and know they would be listened to. One staff member said "we are encouraged to speak up if we have any concerns, which I must say I never have. I would speak to the team leader first then take it from there. The office is very accessible." Another staff member when asked what they would do if they had any concerns said, "I would report it straight away and feel it would be dealt with straight away."

Safeguarding and whistleblowing policies were in place and worked in line with Local Authority safeguarding procedures. The provider had notified us of any concerns. There had been one safeguarding referral where a person had fallen after being discharged from hospital. The provider had taken appropriate action to prevent future reoccurrence and updated the persons care plan. All staff had received training, were able to recognise the signs of abuse and could tell us what they would do in the event of a safeguarding concern.

We found that all risks to people were assessed on an individual basis and there was guidance and information for staff in people's care records. Clinical tools were used to inform risk assessments, for example the 'Waterlow score', which gives an estimated risk for the development of pressure sores; and 'MUST', which is a five-step screening tool to identify people who are malnourished and at risk of malnutrition. Risk assessments included for instance, falls, moving and handling, hydration, fire and evacuation, choking, skin integrity and the use of bedrails. People at risk of falls had detailed assessments and procedures in their care plans and these had been updated following an incident.

There were enough suitable staff available to meet people's needs. This was evidenced by rotas and feedback from people, relatives and staff. People's care plans evidenced dependency assessments to determine the level of care they needed. On the day of our inspection, we did not see anyone waiting for attention. One relative said, "We visit twice a week and (their relative) is always ready…When (their relative) needs the toilet they go to get the hoist quickly enough." One staff member told us how they can spend as much time as they like with people and there is no rush to get jobs done. Three managers were additional to the staff numbers and would help if needed. The provider did not need to use agency staff.

Safe recruitment processes were carried out by the provider. The appropriate checks were made to ensure only suitable staff were employed to support people. New staff were asked to complete an application form and to provide a full employment history. Interviews were held to assess their suitability and aid the decision-making process. References were followed up and all staff had been subject to criminal record checks before starting work. These checks were done by the Disclosure and Barring Service (DBS) and supported employers to make safer recruitment decisions and prevent unsuitable staff being employed. Likewise, all nurses PIN numbers were checked at recruitment and monthly thereafter. Nurses are registered with the Nursing and Midwifery Council (NMC) and given a PIN number. Providers are required to check their PIN numbers with NMC.

There were good systems in place for medicines ordering, storage and administration. The provider used an electronic system for this. Ordering was made easy using the system, this was normally done by the deputy manager but other nurses knew how this worked so could do this if the deputy was unavailable. Medication was stored in a trolley locked to the wall in a locked room, and was well organised. Excess medicines were in locked cupboards and were not over stocked. The room and fridge temperatures were checked daily and recorded and were within acceptable limits. Surplus or discarded medication was disposed of appropriately. Only nurses administered medicines and they wore tabards to avoid being disturbed. They were able to tell us about the system and processes and documentation was clearly completed. We observed how a newly appointed nurse was supernumerary for two weeks to prepare for their role. Nurses took an "exam" before being able to use the computer based medicines system and were assessed by the deputy manager before giving medication alone.

We observed medicines being administered safely. The system had information on why people took their medicines and would prompt the nurses to check if people needed PRN medicines for pain relief. PRN is a term for medication given 'as required', for example Paracetamol. There were safeguards in place to prevent medicines errors. For example, it was not possible to sign for a medication if the dose would be exceeded within 24 hours if it was a PRN medicine. The system included photos of people being in colour if medication was due at that time, which would then grey out when all medicines had been given for that person. The electronic system required nurses to check whether residents were in pain and record this if they were on PRN pain relief medicines. There was a pain board available which had pictures on it for people who were not able to express the level of their pain verbally.

There was one error of a liquid medication where the date it was opened was recorded and an expiry date of three months later was entered. It should have been discarded 28 days after opening but had been given for a further four weeks. The medication is a muscle relaxer and was used to help one person with muscle spasms. We spoke to the registered manager about this who took immediate corrective action. This included researching the medicine with the manufacturer and a head pharmacist to see if there were any adverse indicators of administering past 28 days from opening. It was confirmed that the medicine remains stable for 60 days after which its efficacy is reduced and there is a risk the solution can breakdown and lead to bacterial growth. The medicine was checked and there was no evidence of this, therefore the pharmacy advised there would be no adverse effect to the person. This was reported to the local authority and the registered manager had followed the guidance for the professional duty of candour through informing the persons relative. The registered manager had taken action to prevent reoccurrence by contacting the GP to review the on-going requirement for the small dose or to have smaller bottles prescribed.

All the necessary health and safety checks and audits for the environment and equipment had been undertaken to ensure the environment was safe and testing certificates were available. For example, fire safety, water temperatures, legionella, window restrictors and call bells. Checks were carried out as regularly as they were meant to be and were organised into daily, weekly and monthly tasks. Fire evacuation procedures were in place and records of fire evacuation drills showed the provider could be assured that people could vacate the premises safely if a fire were to break out. Fire alarms, fire doors and emergency lighting were all tested regularly. There was a fire risk assessment and all residents had a personal emergency evacuation plan in place.

Staff understood how to prevent and control infection and people confirmed that staff followed procedures, for example wearing gloves and aprons. An infection control audit had been completed and had not identified any issues or action points. The home was well maintained and cleaned to a high standard.

The registered manager analysed accidents and incidents through their electronic system. This enabled

them to see an overview of incidents per month and by type, look at the outcome of the incidents, identify any trends and learn from the analysis. Improvements had been made as a result, for example one person who fell, now has sensor mats next to their bed.

Good

Is the service effective?

Our findings

People's needs were holistically assessed before moving into the home and these assessments were available in people's records. Assessments were person centred and included the needs of people, for example they covered psychological needs, physical needs, cognitive needs and maintaining independence. Key areas of people's care were developed into comprehensive care plans within the first week of their admission and all care plans were completed within four weeks of admission.

People's individual protected characteristics under the Equality Act 2010 were considered during pre-admission assessments, where people were happy to discuss these. This means people were protected from unfair treatment in relation to identified personal characteristics: people's age, disability, race, religion, gender, sexual orientation and gender reassignment. Staff had received training on this. Staff told us that there was a regular Christian service and one person had their own minister visit them. Although they did not have residents from other religions at present they were making contact with other religious leaders in the area so they can meet the spiritual needs of future people.

All the nurses and the deputy manager were knowledgeable about people's needs and were experienced in the care of older people. They understood all the common conditions experienced by those receiving long-term care and knew where to find information if people with anything less familiar needed care. The provider ensured managers, nurses and care staff had the right induction, training and on-going support to do their job. Staff recruitment files and training records confirmed this. Inductions were structured and included orientation to the home, introductions to other staff, observations of care and assessments of the new staff competencies. All staff new to social care completed the Care Certificate which is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sector. Staff told us they had received an induction, on-going training, competencies and supervision. One staff member said, "The induction was very comprehensive. There is on-line training. I feel I have enough training but you can request other training. I am attending a three-day medication training next month." Training included all the expected areas: health and safety, infection control, fire safety, safeguarding, first aid, food hygiene and manual handling. In addition, training was provided to ensure staff could meet people's needs. For example, in communication, mental capacity, dementia awareness, fluid and nutrition and conflict resolution. Nursing and care staff received periodic supervision and this was evidenced in staff files. Staff had not had annual appraisals yet as they had been working at the service less than six months.

People were supported to eat and drink enough to maintain a balanced diet. People had the involvement of a dietician and nurses had completed meals and drinks assessments. These stated there should be food and fluid charts but these were not always completed. However, we found this did not have any impact on people as weight monitoring showed people's weight was stable and any risk of malnutrition and dehydration was well managed. There was information in the kitchen regarding people's dietary needs and preferences, for example one person was on a softer diet due to their risk of choking. People were offered drinks regularly and fruit and biscuits were always available in the dining rooms. Feedback on the food was very positive. One person told us how they can choose what they want and said, "I am jolly lucky." One

relative said, "There is a really good choice, the meat is always tender. I have eaten here. We have had friends down and used the private dining room." We observed the lunchtime meal in both dining rooms and saw that people were enjoying the mealtime experience as a social event. People were sitting together, talking with each other, smiling and laughing. People were offered choice, for example if they wanted white or brown bread, soup or salad for a starter and were encouraged to have as much as they wanted to eat and drink. People were given assistance with eating where needed and some people chose to have lunch served in their room.

People were supported to live healthily and access the healthcare they needed. The provider worked closely with other organisations and health professionals to ensure people received the care they needed and that they were supported with various health conditions. For example, people's GPs and opticians, the palliative care team, urology nurse and older adults mental health team. Visits and telephone conversations with other professionals were clearly recorded. The electronic system enabled excellent information for transfer to hospital. For example, people's medicines records could be printed as well as a front page of people's care plan with information such as diagnoses and their most significant care needs.

People's needs were met by the homes facilities which were accessible for everyone. A lift provided access to the upper floors and bathrooms contained specialist equipment to enable people to bathe and shower safely. The garden was accessible and secure, and some people used it a lot. Two people with dementia went in and out of the garden as they wanted which offered them choice and some liberty while keeping them safe. Where needed, people had specialised equipment, for example around their mobility needs. The registered manager had paid good attention to ensure the home met the environmental needs of people. The environment was bright, clean and tidy. The décor was suitable for people with dementia and those with visual problems. There were contrasting colour toilet seats and hand rails in toilets and in corridors. The flooring was consistent and without patterns to avoid confusion. Dementia friendly signage was used to help people find the bathroom or dining room. There were memory boxes outside people's bedrooms to help them find their room, and there were reminiscence shelves containing various objects to remind people of their past. This all helped to maintain the independence and dignity of people with dementia.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found that the provider was working within the MCA and where needed, people had a DoLS authorised or they had been applied for. The DoLS in place were subject to conditions and the provider was complying with these. The provider had trained and supported staff to understand the requirements of the Mental Capacity Act in general, and the specific requirements of the DoLS. Staff could demonstrate their understanding of this. People were asked to consent to their care and care plans had been signed. Where people had a Lasting Power of Attorney (LPA) in place, this was recorded in people's care records. A LPA is a legal document that lets the person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.

Good

Is the service caring?

Our findings

The general atmosphere in the home was cheerful and we saw staff and people laughing together. We observed many warm and caring interactions between staff and people and there was evidence of appropriate touch. Staff knew people well and interacted with them politely and with respect. One person said, "Everybody's very kind to me here, I don't want to be in a home but this is as good as it could be, I have nothing to complain about." Another person said, "Staff are pleasant, they are not over friendly but friendly. They respond to my questions and do something about it." Staff said, "I chat with the residents so that I can get to know them and care for them in a way that is best for them." Another staff member said, "I get to know residents by looking at their notes and sitting with them and their family. There is no pressure on the amount of time spent with residents in a social time." One relative, when asked how their loved one is treated by staff said, "Oh, they are good! (relative) has a sense of humour, they have a laugh. The elderly need to feel important and they do that for them."

A relative who visited their loved one daily said, "I was so impressed by the welcome the first time I walked in the door, they showed me around and made me coffee, I can't praise it enough…The staff and residents here are like an extended family…The staff are calming and welcoming." The same relative told us that they had looked at several homes and this one stood out as so much better and that they didn't have to worry as they had confidence in the care their loved one received. They told us when they first came they saw staff use the hoist and said, "I didn't know those things existed but they were so efficient and let me stay so I knew (my relative) was safe."

People were involved in their day to day care and developing their care plans as much as possible where they wished to. One person said, "Yes I am involved, if there is something I didn't like, they would take notice." Relatives told us they were kept informed if anything happened and were involved with care reviews. A relative told us, "Staff ring me to reassure me, they knew I was worried about (relative) and they phoned me to tell me it was alright. The residents are a lovely mix and they get on really well. I think that's because of the relaxed atmosphere." Another relative told us how they were involved with the decisions about their loved one moving downstairs. The registered manager told us that people were not accessing advocacy services currently as their relatives spoke on their behalf, where needed. However, they would refer them to the relevant service if required. Advocacy services offer trained professionals who support, enable and empower people to speak up.

People's rights to a family life were respected. Relatives told us they could visit whenever they wanted and were made to feel welcome. One relative said, "Visitors are always accommodated. We never feel as if we are in the way." On the day a person moved into the home, their relative was invited to eat with them. Some relatives visited every day. Staff were welcoming to our inspection team as well as to visitors. They were open and willing to talk to us, offering every courtesy.

Peoples' privacy and dignity was respected by staff. For example, one staff member described how they covered people up on the toilet and when washing people, they only uncovered the area to be washed. Another staff member said, "I make sure the door is shut…I try to keep people covered as much as possible.

I talk to people and tell them what I am doing." Appropriate systems were in place which ensured information held about people was secure. People's independence was promoted by staff. For example, one staff member told us how they will put the persons toothpaste on their toothbrush, run the water but leave them to complete the task and will prompt where needed. Another staff member said, "I will encourage people and ask if they are able to do tasks themselves or if they need assistance." We observed how people were encouraged to eat themselves at meal times.

Good

Is the service responsive?

Our findings

People's care plans contained person centred information, for example the need to approach a person from the left as they are hard of hearing in their right ear. One person with dementia had a good communication plan which included information on their hearing aid, keeping their glasses clean, having adequate light, being aware of body language and the type of approach to take. Another person had a care plan on cognition and mental health which suggested causes to investigate in the case of confusion. There was a "This is me" section in people's care records being developed. For one person it had details of the job they used to do, their interests and their family.

People's care plans had been reviewed regularly and updated when people's needs changed or more information was learnt about the person. The home had a schedule for 'resident of the day' where they would review all that person's care. People were receiving care which met their individual needs and effective outcomes were achieved. For example, there were pictures of wounds which clearly showed improvement. Another person who had behaviour that challenges when receiving personal care had settled into the home and their instances of behaviour that challenges have decreased. All care staff had access to the electronic system to view people's care plans and write their records.

The registered manager was aware of the Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Providers of health and social care services are required to follow the standard to make sure that people have every opportunity to understand and be involved in their care plans and documents on an individual basis. People's communication needs were met around their communication, for example accessible signage and people's care plans included a section on communication to detail their individual needs.

People were supported to take part in activities they liked within and outside of the home. There was a yoga instructor in the home the morning of our inspection. It was their first visit, they had a nice manner with people and made an effort to include as many people as possible. Many people participated and appeared to enjoy it. One person told us, "Yes, I really enjoyed it, she's going to come back again next week, I'll definitely go". The registered manager was continuously developing new activities for people. For example, they had made connections with the local bowls club, the local school choir and local toddler groups to visit the home.

People were encouraged to engage with activities they enjoyed. For example, one person liked to play cards and staff arranged this. There were good resources available such as books and puzzles along with an activity room. The activity co-ordinator had a weekly plan of activities. There was an exercise class with music, printed pictures of 'yesterday memories' for people to look at and scrabble afternoons. The registered manager had set up a delivery of reminiscence boxes with the local library which also helped them to plan activities. They had access to a minibus once a week and planned trips locally. For instance, they went to their local church for a music concert in July. The activity co-ordinator would do a trial run of the trip to assess if it was accessible for people. There was a hairdresser in the salon on Saturdays. One

relative told us, "We know where we can get the information for activities. A guy does exercising every other week. They have a bit of a sing song and have a quiz. My (relative) goes in the garden and they went on a trundle down the highstreets the other week."

People and relatives could raise any concerns or complaints they had. People told us who they would talk to. One relative, when asked if they have made any complaints said, "No, but I feel it would be dealt with properly." Another relative said, "No. It's been excellent. I would speak to the manager and would be listened to." The complaints procedure was available in a handbook in people's bedrooms and was displayed in the reception area. The registered manager told us that where people lack capacity, their relatives speak up for them and they have provided a copy of the complaints procedures to these relatives. They have also read the procedures to people that may struggle to read it and the administrator is working on an accessible picture version. We saw that the provider actively sought feedback from people and their relatives. A residents meeting was planned and a survey was being developed. There was a comments book for visitors in the reception area. Complaints were recorded, monitored and managed appropriately. At the time of our inspection there had only been a couple of minor complaints from relatives which had been resolved.

There was an advanced care plan in place for one person described as end of life. They had anticipatory medication in place and their relatives had been involved. The person did not want to talk about their end of life and in line with their wishes, their relative thought it would be best for their loved one to remain at the home, rather than go into hospital. One nurse had previously worked for the hospice community service and was very experienced with end of life care.

Good

Is the service well-led?

Our findings

There was a registered manager in post at the home. 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.

Relatives told us they thought the home was well managed. One relative said, "They provide what each individual needs. They are friendly, approachable, they care for the residents and try to keep them happy." One relative described the registered manager as "Bright, breezy, understanding and easily approachable." The registered manager and provider promoted a positive, person centred and professional culture, had good oversight of the quality and safety of the home, and risks were clearly understood and managed. The provider supported good governance through using a system which alerted the registered manager to any incidents, for example medication errors or falls. Senior staff felt supported by the provider, were clearly committed to their roles and held a clear vision of high quality care. One senior manager said to us, "The home I worked in before, everyone's faces were grim. The big difference here is that everyone is laughing and smiling." The registered manager described the provider as "doing what it says on the tin" and told us how the provider's regional team visit monthly to support and audit the home.

Internal audits were completed, for example on finance, health and safety and maintenance. These were used to check compliance and produce action plans. Record keeping was good and was made easily accessible for staff. There was an electronic system outside people's bedrooms where staff could quickly update people's care records and complete monitoring charts. The registered manager promoted continuous learning by reviewing audit action plans, complaints, promoting feedback and analysing accidents and incidents. Action was taken where needed as a result of the analysis. For example, the implementation or review of people's risk assessments following incidents.

Staff told us the management treated them all as part of the team. The deputy was involved with care on the floor and was extremely knowledgeable on the needs of people. Staff told us they felt supported by the management team. One member of staff said, "Support is there if we need it. The management are very good here…They ask for feedback…They do listen…I know the managers door is always open." Another staff member said, "I am always asked if I agree to extra work or a change of days. I feel very supported in my work." The registered manager told us how they are completing a leadership programme for 'compassionate leadership in dementia care'. From this they are using mindfulness and relaxation techniques to support their staff. Staff were encouraged to complete further training which was identified during their supervisions. There was a management on-call system in place to support staff and nurses at the home out of office hours. Good communication and staff engagement was promoted. Management and team meetings were held, heads of departments met daily and there were good clinical handovers between nursing and care staff twice a day. Key messages and actions were also communicated via the electronic system.

The management team was open and receptive to feedback. They engaged with people and relatives

through meetings, day to day conversation and by publishing newsletters. These informed people about anything new within the home, updates on staffing and planned events and activities. The newsletters were also used to share and respond to any feedback received. Surveys were being developed for people and relatives. The management team worked in partnership with other agencies and engaged with their local community. For example, the client services manager was a 'dementia friends champion' and was involved with community liaison with local businesses; The provider had held a champagne reception for professionals in the local community who provide care and support for older people; and one of the senior staff had been involved with fundraising for charity.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, deprivation of liberty safeguards (DoLS) authorisations and deaths. The registered manager was aware of their regulatory responsibilities, had notified CQC about important events such as deaths that had occurred and had met all their regulatory requirements.