Exmouth Care Ltd

Amberwood Nursing 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

This comprehensive inspection took place on 17 and 20 April 2018. The first day of the inspection was unannounced. This meant that the provider and staff did not know we were coming.

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

Amberwood Nursing Home is located in the seaside town of Exmouth. It is a two storey detached building with a passenger lift enabling people to access all areas. There is a main communal lounge and small dining area where people could spend their time as they chose. To the rear of the house is a well maintained secure garden with patio doors leading out and parking to the front. The service is registered to provide personal and nursing care for up to 24 older people. There were 17 people using the service on the first day of our inspection.

We last inspected the service in January 2016, at that inspection the service was rated as good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

Why the service is rated good

There was an experienced registered manager who managed Amberwood and the provider's other service, which is also in Exmouth, Linksways. A registered manager is a person who has registered with CQC to manage the service. Like registered persons, 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 the time of the inspection, the acting manager was running the service as the registered manager was on leave.

Safe recruitment procedures were in place and appropriate pre-employment checks were undertaken. There were sufficient number of staff on duty to care for people safely. Where there were any shortfalls the provider used the services of a local care agency to provide care at the home. Staff were up to date with training; Staff had completed additional training courses linked to the needs of the people using the service. Equality and Diversity was part of the provider's mandatory training requirements and people were cared for without discrimination and in a way that respected their differences.

Care records contained detailed risk assessments. People had individual personal emergency evacuation plans in place. The management team recorded and monitored accidents and incidents. Regular maintenance checks and repairs were carried out; all areas of the service were clean and tidy.

People were supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The management team had made submitted appropriate Deprivation of Liberties Safeguards DoLS applications. At the time of our inspection there were four applications submitted. Mental capacity assessments were undertaken and best interest decisions were recorded.

Staff felt well supported and participated in regular supervision and appraisals. Staff said regular staff meetings meant they felt involved with the development of the service.

People were supported to maintain their health and wellbeing and had access to health professionals when needed. An external company provided meals at the service with a rolling four week menu which took into account people's likes and dislikes. People were on the whole happy with the food they received. Snacks and drinks were available when people required them. People's weights were monitored regularly and advice sought from GPs if there was any cause for concern.

People and their relatives were happy with the way care was delivered and happy with the staff approach. Staff interacted positively with people who used the service and had a good knowledge of the people they cared for. Staff provided care in a way that protected people's privacy and dignity and promoted independence.

People were receiving care that was tailored to their individual needs. Care plans contained detailed information, including life history, to help staff support people in a personalised way.

The management team were committed to ensuring people experienced end of life care in an individualised and dignified way. They worked closely with the local hospice team and provided a service for people requiring end of life care. There were numerous thank you messages from relatives regarding the good quality care people had received at the end of their lives at the service.

A staff member was responsible for co-ordinating activities; there was a varied timetable of events. They were new to their role and with the management team's support, they were putting in place plans to develop activities further at the service.

There was a complaints procedure in place and people knew how to make a complaint if necessary. The provider had a quality monitoring system at the service. The premises and equipment were well managed to keep people safe. Records contained accurate and up to date information relating to people's care needs.

Staff meetings took place regularly and staff felt able to discuss any issues with the management team. Feedback was also sought in a variety of ways from people using the service and relatives. Staff spoke highly about the registered manager and management team.

The service had close links with healthcare professionals who gave positive feedback regarding the knowledge and cooperation of management and staff.

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**

Amberwood Nursing 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 comprehensive inspection took place on 17 and 20 April and the first day was unannounced. The inspection team consisted of one adult social care 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.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners for the service and the local Healthwatch team to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used information the provider sent us in the Provider Information Return (PIR). 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 spoke with eight people who used the service and two relatives. We spoke with nine members of the staff team including the acting manager, two nurses, the activities co-ordinator, four care staff, the maintenance person, a member of the housekeeping team and the cook. We also spoke with one of the provider's.

We reviewed three people's care records and three staff files which included recruitment, supervision and training information. We reviewed medicine administration records for five people as well as records relating to the management of the service. We contacted 14 health and social care professionals who have worked with the provider, to ask them their views about the service. This included local GP surgeries, physiotherapists, tissue viability nurse, bladder and bowel nurse and the speech and language team. We

received seven responses.

Good

Is the service safe?

Our findings

People said they felt safe at Amberwood Nursing Home and they were well supported by staff. Comments included, "Yes, the staff are always very helpful. They are always there if you want anything. I have no complaints at all" and "I don't have any worries." A relative said they had never seen anything that concerned them and if they had any concerns "I would try to talk to the nurse on duty."

There were effective recruitment and selection processes to help ensure staff were safe to work with vulnerable people. Staff had completed application forms and interviews had been undertaken. Pre-employment checks were done, which included references from previous employers. Any unexplained employment gaps were checked and Disclosure and Barring Service (DBS) checks were completed. A volunteer who visited each Friday afternoon to undertake activities with people also had their DBS completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff files demonstrated that appropriate checks were undertaken before staff began work.

Our observations and discussions with people, relatives and staff showed there were sufficient staff on duty to meet people's needs and keep them safe. Staff worked in an unhurried way and had time to meet people's individual needs. People, visitors and staff said they felt there were adequate staff levels to meet their needs promptly. The registered manager reviewed people's dependency levels and the staffing levels to ensure they had enough to meet people's needs. The acting manager said they would increase staff levels if needed. "If we say we need it we get extra staff …it is needs driven."

Since our last visit a new call bell system had been installed. The registered manager recorded in the provider information return (PIR) "A call bell system is in place throughout the home and neck fobs are also available for residents when in communal areas of the home. For those residents unable to use the call bell system regular checks are carried out and documented in their care plan and also on intentional rounding documentation." Throughout our visit we saw people had access to call bells. The provider said they had plans to monitor call bell response times with the new call bell system. This would enable them to assure themselves that people were being attended to promptly.

The management team had recruited two new care staff. The acting manager said they would be supernumerary for four weeks. There was a vacancy for a night carer and a full time nurse and the management team were actively recruiting to fill these positions. Staff undertook additional duties and the provider used the services of a local care agency to cover gaps in the rota. Where agency staff were used a personal profile was provided beforehand from the agency to ensure they had the skills needed. Agency staff unfamiliar with the service had an induction when arriving to the home and were supplied with a document which identified people and their care needs.

Nurses administered people's medicines. They had received medicine training and had their competency assessed to ensure they had the required skills and knowledge required. People's medicines were checked in when they arrived at the service from the pharmacy and the amount of stock documented to ensure

accuracy. Medicines were kept safely in locked medicine cabinets. The cabinets were kept in an orderly way to reduce the possibility of staff making mistakes. The medicine fridge temperature was recorded and staff had guidance regarding the required temperature and what action they should take if it was outside of the required range. Where people had medicines prescribed on an 'as required' basis (known as PRN), protocols were in place about when they should be used. This meant that the nurses were aware of why and when they should administer these medicines to people. The pharmacist supplying medicines to the service had visited the home and undertaken a medicines review on 7 December 2017 and found no concerns.

We discussed with the acting manager that two people did not have photographs on their medicine records. They arranged that these were added to help staff identify people when administering medicines. Medicine audits were completed regularly. New audits had been introduced for medicines which were used to keep individuals comfortable at the end of their lives.

Staff demonstrated an understanding of what might constitute abuse; they knew how to report concerns within the organisation and externally such as the local authority safeguarding team, police and to CQC. They were confident action would be taken by the management team if they raised concerns. Since our last inspection there had been no safeguarding concerns.

People were protected because risks for each person were identified and managed. Care records contained risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments associated with people's nutritional needs, hydration, moving and handling, pressure damage and falls. People identified as at an increased risk of skin damage had pressure relieving equipment in place to protect them from developing sores. This included, pressure relieving mattresses on their beds and cushions in their chairs. The provider used a tool which nurses completed daily to monitor if anybody had any changes to their skin integrity. Staff also checked pressure mattresses daily to make sure the pumps were connected, settings were set at the correct weight for the person and the cells in the mattress were rotating.

In the event of a fire, an individual risk assessment for evacuation was in place. This provided information about each person's mobility and communication needs and the support they would require in case of an emergency evacuation of the service. First aid boxes were regularly checked and restocked to ensure they have all of the equipment needed in an emergency.

The home had a pleasant homely atmosphere with no unpleasant odours. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. The provider had an infection control policy in place that was in line with best practice guidance. The housekeeping staff used a cleaning schedule to ensure all areas of the home were kept clean.

Premises and equipment were well managed and maintained to keep people safe. One of the providers took an active role regarding the environment and met with the maintenance person monthly to complete a thorough check of the premises. Where they identified actions, these were carried out. For example, a deep clean took place in some areas as a result of this type of audit.

The maintenance person undertook regular checks. These included portable electrical testing, effectiveness of window restrictors, hot water temperatures, wheelchair checks, weekly fire bells and routes of escape. Wheelchair checks reviewed the safety of footplates, tyres and brakes. Action was taken regarding any found to be unsafe. They also completed monthly individual room checks to look at bed rails, mattresses, window restraints, trailing wires, lighting etc.

External contractors regularly serviced and tested moving and handling equipment, fire equipment and lift maintenance. Staff recorded repairs and faulty equipment. All tasks undertaken by the maintenance person were recorded to ensure there was an audit trail of work carried out. The provider had systems in place to check the water quality at the service annually against the risk of legionella.

Good

Is the service effective?

Our findings

People's needs were consistently met by staff who had the right competencies, knowledge and qualifications. Staff had received appropriate training and had the experience, skills and attitudes to support the complexities of people living at the service.

When staff first came to work at the home, they undertook a period of induction and completed an induction checklist. This included working alongside experienced staff to get to know people, their care and support needs. The registered manager supported staff to complete the Care Certificate, which is a nationally recognised Skills for Care training programme for newly recruited staff. Staff said they felt the induction enabled them to perform their role well. A care worker said, "I did four shadow shifts in total with senior staff. I was shown the fire procedure…got to know their (people's) individual routines and was not counted in the numbers for a couple of weeks."

Staff had regular opportunities to update their knowledge and skills. Staff had completed annual refreshers of the provider's mandatory training. These included fire safety, moving and handling, safeguarding, infection control, food hygiene and diversity. Staff had also undertaken courses in tissue viability, nutrition, dementia, first aid, health and safety, end of life palliative care, anaphylaxis, communication, wound care and sepsis. Staff were happy with the training on offer. One staff member said, "Much much better, lots of training…everybody has to do it even the nurses." People fedback they were happy the staff had the skills required to meet their needs. Comments included, "I am used to the hoist, so I know what's what. Two staff are always used" and "Yes. I am assisted in and out of the chair safely."

Two health professionals said they had delivered training at the service. They commented, "I feel the staff have the relevant knowledge and skills" and "The assessments which I receive seem to have improved after the training and they know where to go if need any further advice." Other health care professionals were also confident the staff had the skills required. Comments included, "I have always found the staff to be caring knowledgeable about their patients and treat them in a dignified manner" and "I have always been impressed with the care and standard of staff. They give a good account of their patient and follow through on any instructions given."

Checks were made to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK. Nurses were supported to undertake training to support them to perform their roles. Training included verification of death, wound care, venepuncture (taking blood) and syringe driver training (a small infusion pump used to administer medicines under the skin often to keep people comfortable at the end of life).

Equality and Diversity was part of the provider's mandatory training requirements and people were cared for without discrimination and in a way that respected their differences. The provider recorded in the provider information return (PIR) "Induction and ongoing training, diversity, dignity and equality training and the use of the champions to ensure that staff are kept well informed and are able to understand the relevance of the

Human Rights principles."

Staff confirmed they received supervision on a regular basis. They said they found the supervisions really useful and were positive about the support they received. Comments included, "Very helpful." The acting manager confirmed staff had a minimum of four supervisions a year. They also said, "These are interspersed with observations, group supervisions and meetings." One staff member said, "They listen to what we say and will take action if we bring anything up." They gave an example to improve recycling. They said the next day the registered manager arrived with recycling bins.

People were supported to have regular appointments with their dentist, optician and chiropodist and other health services when necessary. For example, community nurses, speech and language therapist (SALT) and opticians. Where people had any swallowing difficulties, they had been seen and assessed by SALT. Where the SALT had assessed a person as requiring a special diet and recommended a pureed food, these meals were provided in the required consistencies for people. As a reminder to staff red trays were used for people who required support with their food.

Health professionals said they had no concerns about the service and had confidence in the staff to make referrals promptly. Comments included, "The service provided by the management at Amberwood Nursing home is safe, caring and well led. The nursing team are excellent and follow my guidance", "We receive timely and appropriate referrals and the recommendations are always followed. Staff will call if they are unclear about anything think Amberwood staff are caring, professional and call for GP review when appropriate" and "The staff contacted our service for advice and followed our guidance, they were always polite and caring." People and relatives were confident a GP would be called if required and that GPs had been called. One person said, "I haven't felt all that well with this cough. The GP came and prescribed antibiotics. The optician came and replaced my glasses."

The Mental Capacity Act (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 lacked the mental capacity to make decisions the registered manager and staff followed the principles of the MCA.

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).We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The Care Quality Commission (CQC) monitors the operation of DoLS and we found the home was meeting these requirements. The registered manager was aware of their responsibilities in relation to DoLS and was aware of how to make an application if they needed to restrict a person's liberties. Staff had received training on the MCA and they demonstrated an understanding of people's right to make their own decisions. One staff member said, "I offer them respect and ask what they would like or not to do…always ask them first."

We discussed with the acting manager the limited signage on display around the home to direct people to communal areas and toilet facilities. They said that only one person was independently mobile at the service and everyone knew where the facilities were. They said they would discuss improving the signage

with the registered manager for visitors and future people staying at the service.

People were supported to have sufficient to eat and drink and maintain a balanced diet. When people first arrived at the home, staff gathered information about their dietary requirements likes and dislikes. The provider used an external food company to provide meals to the service. Staff were able to order meals specific to people's dietary requirements. People at risk of weight loss had their weight monitored regularly and further action was taken in response to weight loss and appropriate referrals made. The registered manager recorded in the PIR, "For all new admissions a daily food and fluid chart is kept for the first four weeks and following ongoing assessment will be continued if the resident is found to be at risk of malnutrition or dehydration." Refreshments were regularly provided and additional snacks and drinks were available if people required them.

We observed a lunchtime meal at the service. During our visit people chose not to use the dining room and stayed in the lounge or their rooms. Prior to our second day of inspection, the acting manager said people had taken their lunch in the garden.

People were on the whole happy about the food and said they were offered a choice if they did not want what was on the menu. Comments included, "The food is good", "It's reasonable. A more varied diet would be better… We get mixed veg, but it's not usually fresh. We get enough (to eat)"; "There are no fresh vegetables. You get a choice of two (lunchtime). I do get fruit, cut up strawberries, things like that" and "It's very good. We do sometimes (get a choice) and I suppose they would give us something else. We don't get any fruit (fresh). I am not keen on tinned fruit." The acting manager said people had fresh fruit regularly.

Good

Is the service caring?

Our findings

Staff were kind, friendly and caring towards people. People were seen positively interacting with staff, chatting, laughing and joking. People and visitors said they felt the care at the home was very good. People and relatives' comments included, "It's very friendly, the staff are very good. I quite like it, the staff are all brilliant", "I took a while to settle, but now I have got myself sorted out. The staff are fabulous. A laugh and a joke, it keeps us all going" and "They look after her well, and she seems very happy." A health professional said, "I've always been impressed by the care shown by nurses and carers."

The Amberwood Nursing Home had a culture of compassion and understanding. Staff were considerate and caring in their manner with people and knew people's needs well. Staff were very attentive and spoke and reassured a person throughout being transferred into a chair using a hoist. They then ensured the person was comfortable and had all they needed.

Staff were reminded of the importance of dignity with a notice outside the office door which said, "Put yourself in the residents' potion…be patient." Staff treated people on the whole with dignity and respect when helping them with daily living tasks. We discussed with the acting manager how staff had placed people's protective aprons on ten minutes before they had their meal. One person was left with their apron on for 20 minutes after they had finished their meal. The acting manager said they would remind staff to consider people's dignity. However, people confirmed staff maintained their dignity. Comments included, "They pull the curtains, shut the door. I am well covered (when hoisted)." Staff said they maintained people's privacy and dignity when assisting with intimate care. One staff member said, "I make sure doors are closed when doing personal care…cover in a towel…Always talk to them as equals."

Staff involved people in their care and supported them to make daily choices. For example, people chose where they spent their day and the clothes they wore. One person said, "It's my choice to stay in my room." Staff said they knew people's preferred routines such as who liked to get up early, who enjoyed a chat and who required reassurance and emotional support. One commented they helped to "choose what they want to wear, do they want to be in their chair or in the lounge, do they want the television on. They all have a choice about what time they get up or go to bed."

Staff had recognised one person was unable to tell them how they liked their hair styled. The staff had spoken with their relative and requested photographs showing how they had chosen to have their hair in the past. This showed how staff respected people's individuality and choices.

In people's care plans staff were reminded to seek consent from people before carrying out tasks. People had been asked for their preference of gender of carer which had been respected. Formal consent was also obtained regarding having their photographs taken and staying at the service.

People's relatives and friends were able to visit without being unnecessarily restricted. Visitors said they were made to feel welcome when they visited the home. A thank you note expressed a relative's view on the staff when they visited. It said, "Was welcomed by a cheery member of staff… I was immediately impressed

with the level of cleanliness, adherence to health and safety and housekeeping. In my view the professional, happy and caring demeanour from all the staff …contributes to the happiness and general wellbeing of those in your care."

The atmosphere at the home was calm and welcoming with people living there appearing settled and relaxed. A health professional said, "This home has a welcoming feel to it with friendly and caring staff, and it is a pleasure to visit." The staff were aware that it was people's home and did not rush around. People's rooms were personalised with their personal possessions, cross stitch pictures, ornaments, photographs and furniture.

Good

Is the service responsive?

Our findings

The service continued to provide responsive care to people. It was evident from speaking with the management team and staff that the experience of people mattered; they spoke with pride about the people they cared for and their aim to make it a lovely place to stay.

Wherever possible a pre admission assessment of needs was completed prior to people coming to live at the service. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. This information was used to develop care plans. The registered manager recorded on the provider information return (PIR), "Individual person centred care plans completed on admission these are then reviewed regularly with residents and NOK (next of kin) if appropriate as their conditions or choices change… On admission each resident has a person centred care plan written within the first seven days which is reviewed and changed as needs and choices change."

Staff were familiar with people's history and backgrounds and supported them fairly and without bias. People's care plans were reflective of their health care needs and how they would like to receive their care, treatment and support. Care plans identified people's needs, the aims and objectives and plan of care/action. They guided staff to know how to provide the care people required when they moved into the home.

People's personal information and the relevant people involved in their care, such as their GP, optician and chiropodist was recorded in their care records. This meant that when staff were assisting people they knew their choices, likes and dislikes and provided appropriate care and support. Staff said they found the care plans helpful and were able to refer to them when required. The staff were required to record all interactions with people and the support they gave. This included people's dietary and fluid intake if they were assessed as being at risk.

Relevant assessments were completed and up to date, from initial planning through to on-going reviews of care. Each month the designated staff member would review people's care needs. They would involve people and their relatives according to their individual wishes. The acting manager said they had tried to involve people and relatives in reviews but the feedback from people and relatives was that this was not needed. The staff kept relatives and people informed on a regular basis and gave them the opportunity to discuss any issues. One person said, "I have only been involved when I have had something to say. I did go to an assessment meeting."

We looked at how the provider complied with the Accessible Information Standard (AIS) and found information was accessible. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The PIR recorded regarding AIS, "Each resident within the home has a care plan for communication needs. If a resident has specific needs such as a disability or sensory loss this would be recorded in their communication care plan and an action plan would be developed… Information is given in clear concise sentences and the resident is allowed time to process the

information effectively. We also have the ability to use IT to enhance the communication process thereby improving the access to information." The acting manager said some information was provided to people in accessible formats where needed, to help people understand the care and support available to them. They said this would continue to be developed.

People had information about their communication needs in their care plans to guide staff how to ensure they had the information required. Staff ensured people had their hearing aids in place and had their glasses cleaned. Where one person spoke very quietly the staff requested the speech and language team to come in and look at communication options, which the person had decided they did not require. Following a stroke one person's communication had been impaired; the staff had been building a communication book with them to support them with their communication.

There was one person receiving 'end of life' care at the time of our visit and others who were very frail. People had Treatment Escalation Plans (TEP) in place that recorded people's wishes regarding resuscitation in the event of a collapse. The staff worked closely with the local hospice team and provided a service for people requiring end of life care. Relatives had sent cards to the team thanking them for the care the staff had given their loved one. One of these said, "He couldn't have been in a better place or looked after with such consideration or compassion than you at Amberwood gave him"; "We greatly appreciate your kind and caring help in making Mum's last days comfortable and peaceful." A second said, "The care attention and love that you gave my mum on a daily and nightly basis was extraordinary. You are an exceptional and dedicated staff. I also appreciate so much your support for my relationship with my mum, helping me to feel close to her and her to me in our nightly calls."

A visiting health professional praised the end of life care provided at the service. They said, "I have never had any concerns at all for the level of care, dignity, knowledge shown. One patient arrived in a particularly vulnerable state with end stage disease, and I felt the staff were particularly kind to her in some difficult circumstances. The family also passed on their appreciation. The team leaders are excellent. I highly recommend their care."

The provider recognised the importance of social activities and how activities formed an important part of people's lives. They recorded in the provider information return (PIR), "We recognise that some residents are at risk of becoming isolated from their community links and life within the home due to their condition or personal choices. We have therefore employed a full time dedicated recreation and enabling officer who visits with residents on a daily basis; this allows us to assist the resident to maintain links to the local community and within the home." They had put in place care plans for risk of isolation to ensure staff recognised and supported these people.

People's spiritual needs were met. The acting manager said, "On the first Friday of each month we have a tea and a chat a time for reflection prayer and praise." They went on to tell us that one person had weekly communion and another had a visitor from the church regularly.

The new staff member responsible for co-ordinating activities had developed a varied timetable of events. An activity sheet had been produced to help guide people; these were also recorded on the monthly newsletter. These included chair exercises, cake decorating, arts and crafts, Pictionary and ball games. An outside entertainer visited every six weeks, who plays the piano and does a sing along.

We observed a ball game activity session which four people attended. The ball had questions written all over. When a person caught the ball they were asked the question by their hand. People were fully engaged in the session. People and relatives were positive about the activities on offer. One person commented,

"Organises some activities for us. I enjoy them." A relative said, "They are very good with the entertainments here."

The PIR also recorded, "Our enabler spends a lot of time with each resident or their representative gathering information about their personal history, interests and aspirations. This allows her to build up a profile of the resident and this facilitates staff to meet all of their needs not just their medical ones." This was evident in files in each person's bedroom which were being completed by the recreation and enabling officer to include personal and social histories. They told us they visited people who stayed in their rooms every day and sits and chats with them, does their nails or/and reads books to them. They also explained they had started to develop a memory box for each person. They had asked families to bring along photos and memorabilia that could be stored in a shoe box that will be kept in each person's room as an aid for staff to instigate conversation.

The provider had a complaints procedure which made people aware of how they could make a complaint. The complaint procedure identified outside agencies people could contact if their complaint was not resolved to their satisfaction. This included the local government ombudsman, local authority and The Care Quality Commission (CQC).

People and relatives said they would feel happy to raise a concern and knew how to. Comments included, "They are all very helpful", "I did on one occasion make a complaint about one of the staff. I felt she was a little bit abrupt. That was a long time ago. I complained to one of the senior nurses. It was listened to... I was satisfied", "I have no complaints", "I would speak to the manager. I have no complaints" and "There have been a few little niggles, but I always have a word with the matron. I would certainly recommend it [the home]."

Since our last inspection, there had been three complaints received; the management team had had followed their complaints procedure. Although two referred to concerns about the planned extension and the noise and possible reduction in car parking space. A recent planning application had been passed to have an extension at the service. People and relatives had been invited to a meeting and had seen the plans and put forward their views. The provider said there were no immediate plans to build the planned extension.

Good

Is the service well-led?

Our findings

The service had an experienced registered manager in post as required by their registration with the Care Quality Commission (CQC). They were also registered to manager the provider's other home in the town, Linksways. The registered manager was supported by an acting manager who was developing their role. The provider's two directors took an active role at the service supporting the registered manager and team.

People and relatives were positive about the registered manager and the management team. They said they were approachable and always available if they wanted to talk with them. Comments included, "I know both of them. They are easy to talk to", "She's definitely approachable" and "I think so. (Acting manager) is very approachable." Health professionals all said they felt the service was well led.

Staff were complimentary about working at the service and the support they received from the registered manager and management team. Comments included, "They (management team) listen to everything we say, they are always willing to listen."

In the PIR, one of the aims and objectives was "To ensure that the resident is able to live life to the fullest potential and in the manner of their choosing". This was the culture which was displayed at the service.

Everyone had a clear understanding of their responsibilities and referred people appropriately to outside healthcare professionals when required. The acting manager said they were defining the senior care worker role at the service. Two senior care workers were taking further health care qualifications to help them in their roles. This would include further responsibilities as well as continuing to mentor new staff. They went on to say, "The plan is to always have a defined senior carer on each day." The registered manager had put in place lead roles for staff. These included a dignity and diversity champion and infection control leads.

There was an on call system so staff could always access support. A contingency plan was in place with a list of the management and providers was in place to guide staff should the nurse on duty suffer a sudden illness or crisis.

The provider used a range of quality monitoring systems, including audits which were used to continually review and improve the service. They had taken appropriate action for issues identified in the audits. There were regular audits and checks of medicines, infection control, health and safety and the environment. The registered manager completed a full service walk around and dealt with any concerns found. The PIR recorded, "The directors visit the home on a regular basis, do monthly environmental and quality assurance audits and they promote and support fairness and transparency and an open culture within the home for residents, families and staff."

People and staff were involved in developing the service and kept informed. However two people said they had not had their views sought. One commented, "I haven't been asked for any feedback, but you are always free to put forward any suggestions" The acting manager said they had tried to have meetings but these had been poorly attended. They said "We speak to people daily and keep them informed."

People knew which staff were on duty each day because a white board in the lounge recorded everybody on duty. They were also advised of the date, weather, birthdays and activities. The Amberwood's monthly newsletter also kept people informed. This included, "People's birthdays, staff changes, activities, what was happening locally and puzzles.

The provider had previously conducted surveys of people, relatives, staff and health and social care professionals. They explained that they had found they were not getting many responses. Instead the provider had used a combination of verbal and written questioning, careful listening, staff feedback, family interviews. They had collated the positive feedback which had been shared with people and staff. They recorded at the beginning of the collated information setting out how they had gathered information, "We decided to vary the questions and methods of obtaining meaningful feedback. ….a genuine effort in ascertaining a true reflection of our entire experience for our residents and staff." It also stated that they will be seeking continuous feedback in a reflective and opportune way.

Staff meetings for all staff were held six monthly. The management team also met with the nurses, senior care staff, night staff and catering and housekeeping staff regularly to discuss issues specific to these roles. Records of meetings showed staff were able to express their views, ideas and concerns. Between each shift there was a handover to give staff key information about each person's care and any issues brought forward. The provider had "Cascade forms" which were also used to keep staff informed. A recent cascade form discussed staff breaks and the times allocated. Staff had all signed to say they had read the information.

Records were stored in the staff office and main office which was locked when not in use so was secure and not be accessible to visitors.

The provider kept up to date with current legislation and new guidance. They had developed comprehensive information and guidance for staff about the new General Data Protection Regulation (GDPR) which comes into effect on 25 May 2018.

There were accident and incident reporting systems in place at the service. The provider completed an end of year audit of all accidents within the service. The management team reviewed all of the accident and incident forms to ensure staff had taken appropriate action. There was no formal system to look at trends and patterns.

In October 2017 the service was inspected by an environmental health officer to assess food hygiene and safety. The service scored the highest rating of five, which confirmed good standards and record keeping in relation to food hygiene had been maintained.

The registered manager was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested. The provider had displayed the previous CQC inspection rating on the provider's website and had a copy of the previous inspection in the main entrance to the service.