Quality Care Management Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 2 and 3 July 2018 and was unannounced.

Quality Care Management 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. Quality Care Management provides nursing and personal care. It is registered to provide support for up to 38 older people, most of whom live with dementia. At the time of our inspection there were 22 people living at the home. Support is provided in a large home that is across three floors. Communal areas include two lounges and a dining room.

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

At our last inspection we had seen significant improvement made but they were still in breach of Regulation 17, Good governance. This was because the care plan auditing process needed further development to ensure it identified all issues that needed actioning. At this inspection further improvements have been made and we found no breaches of the Regulations.

People mostly provided positive feedback about staff. Observations reflected staff were kind and showed them compassion. People's privacy and dignity was respected and they were encouraged to be involved in making decisions about their care. Although people were supported to maintain some independence this needed further consideration to ensure this met people's needs. We made a recommendation about this. People were not provided with the support they needed to ensure they received adequate nutrition and hydration.

People were protected against abuse because staff had received training and understood their responsibility to safeguard people. Concerns were reported and investigated. Medicines were managed safely. Risks associated with people's needs were assessed and action was taken to reduce these risks. People and their relatives felt the home was always clean and well maintained. Equipment was managed in a way that supported people to stay safe and people were supported to maintain good health and had access to appropriate healthcare services. The provider's recruitment process ensured appropriate checks were undertaken to ensure staff suitability to work in the home. Staffing levels met the needs of people although at times the deployment of these was not effective. The registered manager told us they would look at this.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. Staff were aware of the need to treat people as individuals and ensure care reflected their individual needs. People told us that how they felt staff had the skills and knowledge to care

for them. Staff received supervisions and training to help them in their role. Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services. People told us they were always asked for their permission before personal care was provided. Where needed people's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA).

Work had been done on the environment to ensure this was well lit and flooring helped to reduce the risk of falls. However, further work could be done to ensure that the environment was supportive to those living with dementia. We made a recommendation about this.

Care plans were in place, detailed and person centred. End of life care plans had started to be developed but these tended to focus on the person's support needs now rather than considering what they might want at the end of their life. Some further work was needed to develop these. Staff reviewed their practices to ensure they were appropriate for people.

People said they had not needed to complain but were confident to do so. There was a process in place to deal with any complaints or concerns if they were raised. We saw complaints were investigated and outcomes shared with people and staff.

The service aimed to ensure good quality care was delivered and there were systems in place to monitor the quality and safety of the service provided. People, their families and staff had the opportunity to provide feedback about the service. Everyone spoke positively about the registered manager's approach who encouraged suggestions to make improvements.

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.

People were protected against abuse because staff had received training and understood their responsibility to safeguard people.

Medicines were managed safely and risks associated with people's needs were assessed and action was taken to reduce these.

The home was always clean and well maintained. Equipment was managed in a way that supported people to stay safe.

The provider's recruitment process ensured appropriate checks were undertaken to ensure staff suitability to work in the home.

Staffing levels met the needs of people although at times the deployment of these was not effective. The registered manager told us they would look at this.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported to ensure they received adequate nutrition and hydration

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs.

Staff were aware of the need to treat people as individuals and ensure care reflected their individual needs.

Staff received supervisions and training to help them in their role.

Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

Where needed people's ability to make decisions was assessed

in line with the Mental Capacity Act, 2005 (MCA).

Further work could be done to the environment to ensure that it was supportive to those living with dementia. We made a recommendation about this.

Is the service caring?

Requires Improvement

The service was not always caring.

Observations reflected staff were kind and showed them compassion.

People's privacy and dignity was respected and they were encouraged to be involved in making decisions about their care.

Although people were supported to maintain some independence this needed further consideration to ensure this met people's needs. We made a recommendation about this.

Is the service responsive?

Good

The service was responsive.

Care plans were in place, detailed and person centred. Staff reviewed their practices to ensure they were appropriate for people.

People said they had not needed to complain but were confident to do so. There was a process in place to deal with any complaints or concerns if they were raised.

Is the service well-led?

Good

The service was well led.

The service aimed to ensure good quality care was delivered and there were systems in place to monitor the quality and safety of the service provided.

People, their families and staff had the opportunity to provide feedback about the service.

Everyone spoke positively about the registered managers approach who encouraged suggestions to make improvements.

Quality Care Management Limited

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.

The inspection took place on 2 and 3 July 2018 and was unannounced.

The inspection team consisted of one adult social care inspector, a specialist nurse advisor 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 including notifications the provider had made to us. This helped to inform us what areas we would focus on as part of our inspection. We also reviewed the previous inspection report and the provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements. This had been completed just after our last inspection. Before the inspection we requested feedback from the local authority and commissioners and received this from one person after the inspection visit. We also sought feedback from other professionals who worked with the staff.

During the inspection we spoke to four people and four relatives. We spoke to nine staff, including registered nurses, care staff, kitchen staff, activity staff and administration staff. In addition, we also spoke to the registered manager. Due to the nature of people's illnesses we were not always able to communicate with them so we spent time observing the interactions between people and staff, in public areas of the home, to help us understand people's experiences.

We looked at the care records for 13 people who used the service and the personnel files for five staff

members. We also looked at a range of records relating to how the service was managed. These included training records, complaints, quality assurance systems and policies and procedures.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person told us "Yes. Look around at how they react, they don't wait for something to happen. It all helps you feel safe". A relative said "Yes, because of the way staff go about their duties. We're quite confident he's safe" and a second relative told us, "They put him by the nurse's station and he has an alarm on the chair, there's a flow or carers and girls. He's safer here than he was at home".'

While we saw that staff responded promptly to people's requests for support when they were aware of them, there were occasions when the deployment of staff meant that people did not receive support promptly. For example, we observed that 'flash meetings' were held every day at 14:00 hours. At this time all staff who provided personal care support were together in a handover. This meant there were no personal care staff available to people. On the first day of our visit we interrupted this meeting as a person had been calling out for 10 minutes for support. Lunch time on the first day of our inspection was disorganised and people did not always get the support they needed as a result. However, on the second day two additional staff were present at lunch time and everyone got the support they needed. The whole experience at lunchtime on day two was more sociable and relaxed. We discussed this with the registered manager who said they would relook at the deployment of staff over lunch times and during 'flash' meetings to ensure people could receive the support they needed.

The registered manager assessed people's level of dependency at their pre-admission assessment and monthly. This helped them to determine the number of staff needed to meet the needs of people. People did not express concerns about staffing levels and staff felt there were enough of them to meet the needs of people. One person said "There's always someone sitting and waiting to help". Another said, "There's usually staff around". A relative told us "I come at all times of the day and you don't see the girls running about. They've got the right balance". Staff also said the way in which the registered manager allocated the staff worked well.

People could be confident they were being supported by staff who had access to information that enabled them to mitigate risks. During the last inspection we were concerned that not all staff were aware of how to use thick and easy (a substance used to thicken fluids and enable safe swallowing). At this inspection the majority of staff had received training on the use of this and we identified no concerns about the way in which it was used or stored during our inspection.

Multiple assessment tools were in place and used to assess risks for people. These included, Waterlow (to assess the risk of skin breakdown) and MUST (to assess the risk of malnutrition). In addition, the risk of falls and the risk of choking was assessed and where there were specific risks for a person these were also assessed. Once the risks were assessed care plans were implemented to ensure staff had information to guide them to reducing risks for people. For example, we saw risk assessments, close monitoring and regular liaison with other health professionals was in place for a person living with a specific condition that placed them at considerable risk from infections. Staff were aware of this and registered nurses were closely monitoring. For another person living with Parkinson's, a plan of care was in place to identify the risks and

aid the management of this. Staff's knowledge of this condition and others, such as diabetes was good. They were aware of people's needs and any risks associated with these.

Equipment was mostly used and managed in a way that supported people to stay safe. We observed one interaction whereby a member of staff tilted a person in a wheelchair slightly backwards to get the wheelchair over a lip in the flooring. This wasn't safe practice and we discussed this with the registered manager who told us they would be in discussion with the provider to look at getting ramps fitted.

Regular maintenance checks took place of equipment, such as hoists and lifts, although at times the records were not held in the home, these were sent to the home when we requested to see them. Window restrictors were in place where these were required. Where it had been assessed that a person required the use of bed rails, staff ensured that protective bumpers were in place to prevent any injuries. The bed rails were checked regularly by staff to ensure they were safe and working correctly. Personal Emergency Evacuation Plans (PEEP) were in place which outlined how people could be removed or kept safe in the event of an emergency, such as fire and flood.

Medicines were stored safely in locked trolleys, rooms and fridges. Staff checked the temperature of medicines storage daily to ensure this would not impact on the medicines effectiveness. Due to the increase in the temperature outside this had increased the temperature of the room where medicines were usually stored. Action had been taken and the medicines trolleys had been moved to an alternative room with air conditioning and CCTV cameras. The administration of medicines followed guidance from the Royal Pharmaceutical Society. Staff did not leave the medicines trolley unlocked when unsupervised. Staff checked the records before administering the medicines and then signed for these once the person had taken them. We looked at the Medicines Administration Records (MAR) and found no gaps in these records. All MARs contained a front sheet with a recent photograph for identification purposes. As required (PRN) medicines had protocols in place to guide staff to the use of these medicines. A system of audit checks of medication was operated and working well.

People were protected against abuse. Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. Staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Staff said they were confident to do so and felt that the registered manager would take prompt action to address any concerns related to people. Records were held when referrals had been made to the local authority and incidents were investigated and appropriate action was taken.

Incidents and accidents were recorded and audited monthly by the registered manager. These audits looked for patterns and trends as well as recording any individual action that had been taken for people. This meant risks to people from incidents were monitored and action was taken to address safety issues and prevent a reoccurrence.

Throughout our visit we saw the home was clean and tidy. One person told us "It's always clean. It's very clean. They're always cleaning, you have to give them credit for that." A relative said "They are always very particular about that. There's never been any smells since he first came here". We did not detect any malodours. All areas, both communal and clinical were clean and tidy. There were ample hand hygiene stations throughout the home. All hand basins contained hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff received training in infection control. There was adequate provision of personal protective equipment (PPE) for staff, such as disposable aprons and gloves which we observed were used appropriately.

Requires Improvement

Is the service effective?

Our findings

People told us they felt staff were trained and knew how to support them. One person said, "Yes. They all seem to be switched on" and a relative said "They seem to be, yes".

People told us they received plenty to eat and drink. On person said "Oh, you're well fed, they bring a book. They say what's on and you say what you want". One person told us that they got a choice but because they were asked to make this choice the day before they sometimes forgot what they had asked for. This person said "The food's not too bad. The day before they ask what I want tomorrow for breakfast, lunch and tea. You have to make a decision for tomorrow. I tend to forget what I've said. I said I'd like fruit for breakfast this morning, tinned fruit, and I've got it".

The kitchen staff were aware of people's needs, likes and dislikes. They knew who needed their meals to be delivered in a soft or pureed format to enable them to eat without risk of choking or swallowing difficulties. However, on the second day we observed that they did not prepare one person's meal to the correct consistency and we intervened and asked the registered manager to sort this out. The records were inconsistent and this had created some confusion. The registered manager took immediate action and addressed this with staff.

People who required support and supervision at meals times were provided with this but this was inconsistent and dependent upon the individual staff member. One person's care plan indicated that they had not been eating very well resulting in weight loss. Their care plan said that they needed full support from staff to eat and drink. On the first day of our inspection we observed one person left alone with their meal and no support. The person did not eat their meal. The second day a different member of staff supported them and provided full support and the person ate more.

People's nutritional risk and weights were monitored regularly. Action was taken should any significant change be noted, including increasing the frequency of monitoring their weight and involving the GP. This information was shared with kitchen staff who were aware of the need to fortify foods.

Most people living at the home, lived with dementia. Work had been done on the environment to ensure this was well lit and flooring helped to reduce the risk of falls. However, further work could be done to ensure that the environment was supportive to those living with dementia. For example, some signage was in place but it was difficult to identify directions from these. Some people may find it difficult to identify their bedrooms as there was no signage to show the room was a bedroom and no signage or pictures to aid people in recognising it was their room. On occasions some rooms had names on the doors for people who no longer lived at the home. People with dementia often find contrasting colours helpful in orientating them however these had not been used.

We recommend the registered provider seek guidance and advice from a reputable source about how to make sure the environment was dementia friendly.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. People told us they and their relatives were involved in making decisions about coming to the home. The pre-admission assessment process identified the areas of support people needed in relation to their health, their social needs and their personal needs. The registered manager used evidence based guidelines to support practice. We saw nationally recognised tools were used to assess the risks of skin breakdown and malnutrition were in place. Staff were required to undertake annual medicine competency assessments in line with National guidance.

22 of 31 staff who provided direct care had completed training in equality and diversity. The provider required all staff including those who did not provide direct care to undertake this. Staff were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. The registered manager was clear that discrimination would not be tolerated and was confident any human rights or equality needs people had would be met.

New staff received an induction and were required to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff were encouraged to further develop their skills and knowledge by completing vocational qualifications in health and social care. Staff felt the training opportunities on offer for them were positive and helpful in their role. They told us training had improved greatly and there was much more available to them now. As well as face to face training, the provider was also using a system of competency based workbooks. Staff told us one of the positive changes since our last inspection, was that when someone new moved into the service they were given competency workbooks to complete that related to any specific health conditions the person may have. For example, a member of staff told us they had just completed this in diabetes and stroke awareness. They could provide us with clear information about their role in supporting the person with their diabetes.

Supervisions with staff had improved since the last inspection and these were being completed more frequently. Staff said these were open discussion which they found useful. They told us these sessions gave them the opportunity to address any concerns and to receive feedback that would help them in their role.

Handovers between staff took place to ensure they were kept up to date about everyone's needs. Staff and the registered manager felt that they communicated well as a team and had developed good working relationships which enabled communication. People had access to other health professionals and we saw records showing that external teams such as GP's, dentists, speech and language therapists and older person mental health teams were involved.

People gave us mixed views about whether they were asked for permission before providing care. One person told us "Oh yes. They treat everyone with respect" and a second one said "No, they tell you what they are going to do". A third person told us "Sometimes it's difficult to understand them, but they're friendly about helping". Our discussions with staff demonstrated they understood the need to ensure people were asked for their consent and during the inspection we heard staff asking permission from people before they provided care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. 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 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood the importance of always assuming a person can make their own decisions. They had received training and had a good understanding of the Mental Capacity Act 2005 and how to apply this in practice. Mental capacity assessments had been completed where needed, although we did find one person's capacity assessment was not decision specific. Where capacity assessments determined a person lacked capacity, best interest decisions had been made involving relevant others. Where DoLS had been applied for Mental Capacity Assessments had been completed. The registered manager had a system in place to track the expiry dates of these and any conditions that were required to be met. One person had conditions attached to their DoLS and we saw these were being met.

Requires Improvement

Is the service caring?

Our findings

People mostly provided good feedback about staff and described them as kind, caring, friendly and polite; although some comments indicated that people were not always satisfied. One person said, "They get cross with me because I want to go to the toilet so often" and another said, "They don't get enough time" to get to know them as a person.

Interactions between staff and people that we observed showed staff were kind and caring. Staff spoke kindly and compassionately with people. They offered reassurance to people when they saw this was needed.

At the last inspection we found that staff's communication could improve and we still found this at this inspection for some staff members. A relative's comments suggested that this may still be an area for improvement. They told us "I've had to tell them sometimes there's too many people telling [them] what to do. It confuses [them] and [they] gets aggressive. [They're] not an aggressive person. I had a phone call and they've said 'Can you come? [They] won't settle'. When I got here, there were four people telling [them] what to do. That's too many for [their medical conditions] brain. I've had to reiterate that to them; [they're] better with one to one." We did not observe this but we did observe on one occasion a staff member tipped a wheelchair back with a person seated in it, to get the wheelchair over a lip in the floor without warning the person of this. On a second occasion we observed another staff member titled the back of a chair backwards without warning the person first. On the first day of our inspection staff were not able to tell people what the lunch time meal was when asked, but also did not make attempts to find out and then let people know.

However, on other occasions we saw verbal communication worked well. For example, one person wasn't eating their meal and only ate a limited range of food stuffs, with staff encouragement, communication and light hearted banter they chose an alternative and ate it all.

The Accessible Information Standard was introduced in August 2016 and applies to people using the service who have information or communication needs relating to a disability, impairment or sensory loss. It covers the needs of people who are blind, deaf, and/or who have a learning disability. Plus, people who have aphasia, autism or a mental health condition which affects their ability to communicate. Information was not always provided to people in a variety of ways which would give them the best opportunity to understand it and be able to contribute. Policies and information on display were in small written text only. The registered manager told us they were not aware of the accessible information standard. No specific communication aids were being used at the time of the inspection, the registered manager told us the need for information to be provided in different communication formats would be incorporated into the pre-assessment process.

Staff's approaches to support mostly showed they supported people with maintaining some level of independence. For example, we observed a member of staff supporting a person to mobilise. This took the person a long time but the member of staff gave plenty of encouragement and didn't rush them. However, one person told us they didn't have any independence and we did see that at times people were not

supported with this because staff felt they needed 'protecting'. For example, one person expressed wishes to retain some of their previous independence that was not being supported at the time. While staff told us this was so the person did not hurt themselves, no risk assessment had been undertaken to determine this decision. Although 'protecting' people may seem like the right thing to do, it does need to be done in the least restrictive, risk assessed way that supports the person to maintain as much independence as possible, for as long as possible.

We recommend the registered person seek guidance and advice from a reputable source on positive risk taking and safely supporting independence.

People were encouraged to express their views and to make their own choices. People were supported to make choices. People were given the choice of where they wanted to eat their meals. Some stayed in the lounge, others their rooms, whilst some chose to go to the dining area. On the second day of our inspection, some people, chose to eat in the garden with a glass of wine.

People and their relatives were involved as much as possible in their care and in having a say about the home. Whilst a number of people living in the home could not recall being involved in their care plan or review of these, relatives confirmed they were. One relative told us the care plan was always available as well as daily records, which they said they also checked. Relatives also told us that meetings took place to provide an opportunity to express their views. One relative said "Yes, it was interactive. You're all treated as family. Any concerns are discussed" and a second said "They are open to suggestions".

People and their relatives described staff who respected people's privacy and dignity. We observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff told us the action they took to ensure people's privacy and dignity was respected when supporting them with personal care.

Good

Is the service responsive?

Our findings

People and their relatives told us they felt Quality Care Management staff responded to their needs and requests. It was apparent throughout our discussion with staff about people that they knew them well. Staff were aware of people's histories, their likes and dislikes. Whilst not everyone knew if they had a care plan they said staff listened to them and knew what they needed.

The initial assessment process identified the person's needs, wants and wishes. From this information care plans were then developed based on the information gathered from the person, their relatives and other professionals. Care plans were detailed and person centred. They provided sufficient information to guide staff in caring for the person and included information about the person's life history and social/activity wishes.

It was evident staff reviewed their practice to ensure that this met the needs of people. For example, a nurse told us how as a team they had discussed the timing of one person's morning medicines as this was not working well for the person. As a result, this had been changed and was successful. In addition, nursing staff told us they had reviewed the need to check blood sugars for people living with diet controlled diabetes on a regular basis and this now took place when the person's physical condition suggested it was needed.

Activities were provided in the home but at times were limited for some people. People provided mixed views of activities. One told us "They have a bit of bingo; I can't stand it, I'm totally against bingo. Once a week or a fortnight a woman comes in with a quiz thing". When asked if they enjoyed this they said "No, there's nothing intellectual." Relatives told is of the activities their family member joins in when they want to. Other people told us how they were supported to go out. One person said "I get taken out in a wheelchair. Sometimes my wife takes me; sometimes the staff. I like being out there. We go mainly to the Canoe Lake". Another person said "One lady, we all feel sorry for her, she takes four people out in wheelchairs, one after another. I'm third. She gets absolutely bushed. She takes me to a pub and we have a drink. I like to have a beer, that's what I have".

The activity staff told us that they made plans for activities but that these changed dependent on what people wanted to do. They were aware of people's likes and dislikes and able to describe how with support and encouragement they had supported one person who did not like to leave the building to go out, by engaging with them in an interest they had. They explained how they engaged with people in who stayed in their rooms. They told us "I go into people's rooms, with one [person they] like a singsong, we watch 'Lorraine' and chat. In the winter there's more inside things. More colouring and catching a ball, it's exercise for them".

On the first day of the inspection we saw that one activities coordinator was working and they took three people out for a walk, in their wheelchairs. They also took one person out for a birthday lunch as this is what they had chosen to do. However, as this member of staff was not in the building this did mean that people in the living room were not involved in any activities beyond having a film put on during the afternoon. On the second day there were two activity staff working and more activity and engagement took place. We saw

some people engaged with singing and dancing, chatting and going out if they wanted to.

The providers had a policy and arrangements in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided. People told us they had not needed to complain but would feel comfortable to talk to staff. The registered manager told us that when concerns were raised they dealt with them straight in line with the provider's policy. Records reflected complaints were investigated and the outcome and learning shared with the person and staff.

At this inspection no one living at the home was at the end of their life. Relatives told us they had been involved in some discussions about their family members end of life care. Care plans had started to be developed but these tended to focus on the person's support needs now rather than considering what they might want at the end of their life. The registered manager told us they were keen to develop these further. Registered nurses were aware of the need to involve a medical team early and source appropriate medicines to ensure they were pain free as well as ensuring any spiritual, cultural and religious needs were understood and supported.

Good

Is the service well-led?

Our findings

People told us that they thought the home was well led. One said, "It runs smoothly". Relatives told us they saw the registered manager often. One said, "they're switched on and know what they're doing". One person said, "I'd like to thank the people who provide it and the people who run it" and a relative said, "I think all the staff work in a professional, but friendly manner. They go about their duties with the love and care you'd expect them to give their own families, from the cleaners, straight up to management".

At the last inspection whilst the auditing process of care plans had improved, the recording of the actions needed was not fully effective in identifying what actions staff needed to take to ensure care records were accurate, complete and up to date for people. This was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection this had improved and was no longer a breach.

Care plans audits continued to be undertaken monthly and any action needed was identified, recorded and allocated to a member of staff for completing. We observed that these actions had been completed within the timescales provided. A number of other auditing systems were in place including medicines audits, infection control audits, health and safety audits as well as other clinical audits such as weights and wounds. These were all completed by either the registered manager or delegated to appropriate staff for completion. They identified any issues of concern, for example weight loss and the action to be taken to address these. Since our last inspection the registered manager had identified that daily records such as repositioning charts required improvement as these were not always completed regularly. These continued to be completed and the findings shared. The registered manager as aware of the need to keep reminding staff of the need to record in these. They said this was discussed at each handover.

Provider visits continued to take place and the last one happened on 11/6/18. This involved speaking to people and relatives as well as observing staff and reviewing rooms and records. Feedback had been positive and no one had raised concerns. Observations reflected timely responses by staff to people's requests and a positive observation whereby a member of staff was heard singing to a person in an attempt to encourage them to get up. Other issues identified included how care plans had been reallocated due to them being insufficiently completed by one member of staff and training to staff given about effective incident recording. Action plans were in place following these and would be checked for completion at the next audit.

People, relatives, and visiting health and social care professionals were asked their views in relation to the quality of care on a regular basis. An annual survey was carried out with people, visitors, and staff. At the time of our inspection this feedback was being analysed but the registered manager had looked at the feedback as this was received. One relative told us "I did a survey. I said the laundry could be better, things went missing. It was sorted out". No other concerns were raised and feedback was positive.

The registered manager engaged with other agencies and the local community. We saw working relationships with the local authority, district nurses, GP and other health professionals.

Staff spoke highly of the registered manager. They all told us how the registered manager continually sought their feedback and asked for suggestions, they said the registered manager listened, took on board any comments they had and where possible made changes. A registered nurse told us how following their suggestion, the registered manager was planning on introducing clinical meetings. All staff spoken to said they found the registered manager and the provider's easy to approach and were confident they took things seriously.