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The Manse Residential Home

Inspection report

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Date of inspection visit: 19 October 2015
Date of publication: 16/12/2015

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

Overall summary

The inspection of the Manse Residential Home took place on 19 October 2015 and was unannounced. The home had previously been inspected in October 2013 and was found to be meeting all the requirements of the Health and Social Care Act 2008.

The Manse is a residential home in Knottingley; close to Castleford and Pontefract. It is registered to provide care for up to 18 older people, both male and female aged 55 and over. Some people may be living with dementia.

The home has accommodation over two floors. There are two lounges and a dining room for communal use and a garden to the rear of the building. However, on the day of our inspection there was extensive refurbishment being carried out by the registered provider who was extending the building to include five more bedrooms with en-suite facilities. This meant that access to the garden and second lounge was not possible. The building was also having many windows replaced.

There was a registered manager in post on the day of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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 told us they felt safe and this was endorsed by visiting relatives and a health professional who knew the home well. Staff displayed a detailed knowledge of how to identify any safeguarding concerns and knew the process of reporting such concerns. Medicines were administered, recorded and stored in line with current guidelines.

Risk was managed through person-centred assessments which were linked if there were related issues such as moving and handling and falls. However, we found that not all assessments had the method of minimising the risk detailed on them and the registered manager agreed to look at these.

Staffing levels were appropriate to people's needs although we acknowledged that staff felt under pressure at times. Staff did visit people who preferred to remain in their rooms at periodic intervals as well and we were aware the home had plans in place for extra staff.

People were supported with their nutritional needs and encouraged to do as much for themselves as possible.

Staff had received all necessary training and it was evident through their interactions with people in the home that they had the knowledge and skills to support people effectively.

The home had followed all the requirements of the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards, ensuring that where people lacked capacity to make more difficult decisions they were in their best interests while supporting people to make as many choices as possible for themselves.

Staff were very caring and attentive to people's needs throughout the day, demonstrating an in-depth knowledge of people's strengths and where support was needed. They pre-empted people's needs and ensured a high level of interaction.

Care records were detailed and person-centred reflecting the ethos of the home and complaints were handled in a thorough and timely manner. Activities were a little constrained by the environmental restrictions but people did engage and enjoyed the music.

The home was well led by a registered manager who had supported staff to endorse the home as being in existence solely for the people living there. This was evidenced through excellent leadership shown in staff support, robust and considered audit systems and a transparency of approach encouraging people or staff to raise any concerns.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

People and relatives told us they felt safe as staff were attentive and responded quickly to any calls. Staff understood how to recognise signs of abuse and what action to take if they had any concerns.

Risk assessments were person-centred and focused on both the specific risk but also how this may impact on other aspects of someone's care needs.

Although staff expressed concerns that at times the service was pressured, we saw they were able to respond quickly and efficiently.

Medicines were recorded, administered and stored in accordance with guidelines.

Is the service effective?
The service was effective.

Good

We found that staff had received an in-depth induction, regular supervision and training to enable then to fulfil their roles appropriately.

People and relatives told us they had well prepared food and we saw that people were supported to ensure an adequate nutritional intake where needed.

The home had acted in accordance with the Mental Capacity Act and its associated Deprivation of Liberty Safeguards and staff demonstrated their knowledge of the Act by their interactions with people.

People had access to health and social care support as required.

Is the service caring?
The service was caring.

Good

Staff were led by people's needs throughout the day and responded in a considerate, patient and attentive manner. It was evident from the interactions they knew people well and were able to pre-empt needs in some cases.

People were supported discreetly and their privacy was respected.

Is the service responsive?
The service was responsive.

Good

We found that activities focused on the communal lounge and that due to the building works, opportunities were a more limited. However, staff did talk to people and engage with them.

Care records were person-centred and detailed, evidencing that staff had taken time to understand about a person's life history.

Complaints were dealt with in a timely and effective manner.

Summary of findings

Is the service well-led?

Good

The service was well led.

The home had a welcoming atmosphere from staff and people living there. Everyone we spoke with was highly complimentary about the home and the staff.

We saw that this was a home providing support based on people's individual needs and that staff had clear expectations of performance highlighted and demonstrated by the registered manager.

There was a robust and rounded audit system in place which dealt efficiently with any issues and used every opportunity to learn from areas where things could be improved.

The Manse Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 October 2015 and was unannounced. The inspection team consisted of two adult social care inspectors.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we had not received this although we were assured it had been sent. We also checked notifications and with the local authority safeguarding team.

We spoke with five people living in the home and two of their relatives. We also spoke with a visiting health support worker. We spoke with three staff including one senior carer, the deputy manager, and the registered manager.

We looked at two care records, three staff personnel records, minutes of staff meetings and audits including accidents, medicines and care plans.

Good

Is the service safe?

Our findings

One person we spoke with told us "Yes I do feel safe. I would say if I didn't". Another person who chose to remain in their room said "I feel safe. I've got a buzzer and staff come straightaway". One relation we spoke with said their relative had been in the Manse for two years and they felt they were "definitely safe as the staff are so attentive". They were aware of sensors in the person's room which alerted staff to any unusual movements. Another relation said "I often visit unannounced and find staff talking to my relative. I feel my relative is 100% safe". They went on to say "I've never seen anyone neglected. Staff know how to handle confused people. They are skilled and I've seen that". A visiting health professional who visited regularly also said that "people are safe and I have no concerns at all".

We also asked staff if they felt people were safe. One member of staff said "Yes people are safe. We have room detectors which are set off when anyone goes into the bedrooms. There have been no safeguarding incidents since I started twelve months ago".

This staff member was able to explain all the different categories of a safeguarding concern such as "physical, verbal, financial, medication – this could be giving the wrong medication or not giving someone their medication". They told us they would try and stop it if they witnessed it and report it to the registered manager, who would then report it to the local authority to investigate. The staff member was also aware if this didn't happen, they could report it to the Care Quality Commission. The staff member had never observed any bad practice from fellow staff members.

The deputy manager said "yes, people get good care. Staff deliver care to a high standard". They explained the purpose of the whistleblowing procedure which all staff were aware of but stressed they'd never had to deal with anything of that nature and neither had they had to deal with any safeguarding concerns but explained in detail what they would do if any issues arose. The registered manager explained that all staff had received current safeguarding training.

We found the service had regularly updated risk assessments. They were person-centred and related to specific risks facing individuals within the home. We saw one completed as the person was at risk of social isolation due to choosing to stay in their room. It stated "[Name] understands they can come downstairs to mix with other residents but when they have a day when their mobility is poor we may ask them to remain in their room for their own safety". This was linked to a risk assessment for this person around mobility as the home did not have a lift, only a stairlift. The mobility risk assessment again focused on the person's varying needs saying "Mobility varies greatly day to day. Some days [name] mobilises really well with the assistance of two carers, turntable and zimmer frame. But other days they don't always stand properly and don't help themselves". This linked to a falls risk assessments as it also indicated this person could try and stand without staff.

Although the assessments focused on the individual they didn't always specify the method that support was to be offered, such as how staff would ensure a safe transfer from standing to the stairlift. We spoke with the registered manager about this and they acknowledged that they had not always recorded the method as to how they would try and minimise the risk but would amend these promptly to reflect this.

Staff told us about the evacuation procedure in event of a fire and people's specific requirements. Additionally if a person had a fall one member of staff told us "We can identify the risks and stop it from happening again. We complete accident forms and pass the information to other staff at handover to make sure it doesn't happen again, as much as we can". This was echoed by the deputy manager and we saw evidence in the files of a post fall evaluation where we saw accidents analysed looking at areas such as whether the person was using a walking aid at the time, had the correct footwear on, whether they were displaying signs of unrest or whether there were other external factors such as a wet floor or clutter. Following this analysis was a detailed action plan which included time-limited close observation and a record of any injuries with ongoing monitoring.

We noted one accident form had been incorrectly completed but this had been identified by the registered manager who had spoken to the staff in question at the time and offered further guidance on the procedure. One relative we spoke with said staff knew their relation well that "they are pretty quick to pick up on infections before they get hold" which helped to minimise the risk of falls.

Good

Is the service safe?

The home also conducted monthly analysis of falls to identify any overall trends in addition to looking at the specifics of the individual falls. This included assessing whether all appropriate action had been taken in each case and whether they needed reporting.

One member of staff told us "if we see someone who wants to have a walkabout, we would walk with them" to minimise the risk of falls. We observed this later in the day when someone wished to use the bathroom and the member of staff ensured they were escorted safely to the door which was particularly important as on the day of our inspection due to the workmen active in the building. We saw that people received appropriate and regular pressure relief whether sitting in the communal area or in their own room.

We asked people living in the home about staffing. One person told us "It depends on the time of day. At dinner it gets a bit tight". We asked the person how long it took care staff to answer the call bell at this time and they told us "it depends on how long they have to go to look for a second person". One relative told us "Everything is in place that needs to be. There are always two staff on the shop floor. You can always do with more in these types of jobs".

We asked staff their view and one member of staff said "it is alright most of the time but when you've got nurses coming in and you are trying to do medication, it's difficult and you wish you had another pair of hands". They highlighted the busiest part of the day was evening when more people became vocal and "we spend time calming people down". Staff also told us about the use of distraction techniques where people became more agitated. Another member of staff said "People can become quite vocal but we will sit with them. Offering a cup of tea usually works".

Staff also advised us that neither agency or bank staff were ever used and that the weekends had the same ratio of staff as weekdays. We also saw that there were always two staff on duty at night with a further member on call. One member of staff said they were sometimes asked to extend their shifts for a couple of hours to manage sickness of colleagues but this was always from the regular staff team and would be arranged by the registered provider. Although staff had said there were pressure points we saw that throughout the day and early evening staff were attentive and quick to meet people's needs.

The deputy manager said they had recruited a new person to cover some night shifts but were currently awaiting Disclosure and Barring (DBS) checks. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. They told us once this person is in post this would free up some time for staff to cover more day shifts. The health professional who visited the home told us "I'm never running around looking for staff. The longest I've had to wait is about two minutes. The staff always ask who I need to see and then get each person ready for me". They also said "I see regular faces here as the staff group is the same". The home was employing staff following safe recruitment practices and a comprehensive interview.

We observed the senior carer completing the medicines round. They found the person's medication administration record (MAR) which had a photograph, date of birth and any known allergies listed. They were able to show at what time the medicines were to be administered and how this corresponded with the prescription information by checking the contents of the blister pack against the MAR chart. Inhalers were stored under each person's name in the medicine cabinet and contents of these boxes were checked each time the medicine was administered.

They explained how PRN (as required) medication was administered such as asking the person if they were in pain and then offering them painkillers, and there were appropriate records to reflect this. No one in the home on the day of our inspection was on covert medication.

Prior to administration the record was dotted to show the tablet had been removed from the blister pack. The member of staff placed each tablet in to the person's hand and encouraged them to have a drink. They displayed considerable patience as the person took a number of attempts to swallow each tablet. The member of staff did check to ensure the person had actually swallowed them. The person was also assisted to use their inhaler. After this medication was given the records were initialled to show that it had been taken. We observed this sensitive approach each time medicines were administered. Due to the work taking place in the building people were supported to have their medicines in the communal lounge which did not afford much privacy.

Good

Is the service safe?

The member of staff explained that if a person refused their medication they would return a little later to see if they wished to take them at this point. They also said if a person spat out their medication they would dispose of this in a bag provided by the pharmacist and record on the MAR sheet that the person had refused their medicines. Where people's medicines were not in the usual blister pack due to being on respite for example, boxes were clearly labelled and descriptions of their contents minimised the risk of errors.

We also spoke with the deputy manager who explained "I make sure I have everything ready on the trolley prepared: water, cups, gloves, aprons, anything I need for the round". They also stressed they are checking they are giving the medicine to the right person. Each member of staff who is authorised to give out medication had received the required training and been observed by the registered manager at least three times before doing it alone. The deputy manager said there had never been any medication errors to their knowledge. The staff member we spoke with said their competency had been checked two months ago and we saw evidence of this.

We saw evidence of both weekly and monthly medication audits which checked how medicines were stored, if stock levels reflected the records and whether records had been accurately completed. Medicines were stored safely including controlled drugs which were stored in line with required legislation. Fridge and room temperatures were checked before each medicine round ensuring the home was monitoring effectively how the medicines were stored.

Good

Is the service effective?

Our findings

When we asked people about the food we were told by one person "It's generally good. The apple crumble is lovely as it's homemade". Over lunchtime we heard people talking to each other. One person said "Did you enjoy that?" The reply was "Can't you tell by the contented look on my face?" Another person told us when we asked them about the food "I'm not a good vegetable eater but I do get plenty of meat. I am a poor eater so I'm often not hungry". We saw that this person was being monitored for their food intake.

A relative visiting the home told us "My family member loves the food, especially the Sunday dinner. When they were unwell the home kept a food chart as my relation had decided not to drink tea or coffee. However, staff offered them milk and this is still offered". Another relative said "It's simple homemade food. I've known if someone asks for a drink, we've seen staff go and get one".

We observed the lunchtime experience. People were assisted from the communal lounge into the dining room next door. If people were able to mobilise independently they were encouraged to move to the dining room but staff were extra vigilant due to the extra risks posed by the building work.

The dining room contained three separate tables with a tablecloth, cutlery, condiments and placemats. People chose where they sat. Meals were brought individually and were pre-plated but were an appropriate portion size. Most had gravy already on which restricted people's option to choose for themselves. People were offered a choice of water, juice or tea and the member of staff displayed knowledge of people's preferences, prompting where required. One person could not decide so was given both juice and tea to make their own choice. Some people were offered aprons t to wear o protect their clothing.

People had the appropriate equipment to help them eat independently such as a plate guard to ensure the food was easier to handle. They were supported at regular intervals by the member of staff who helped, after asking the person, by cutting up their food and putting it on the fork. However, they enabled the person to feed themselves rather than taking over. One person who was quite anxious asked if they 'could go now?' The member of staff supporting encouraged them to try and eat a bit more and also offered them a further drink. The member of staff had knelt down beside the person during this whole conversation to try and establish a more direct relationship.

Another person was supported eat a bit more and reassured as they were struggling without their glasses. The staff member had reminded them at periodic intervals their glasses were being mended at the opticians. They discreetly asked the person if they would prefer to use a spoon for their meal as they may find this easier. When people had finished they were all asked if they had had sufficient to eat. Desserts were offered to people and they were addressed individually. Again this already had custard on it which limited the choices people could make. However, we did acknowledge the cook had an in-depth knowledge of people's preferences and regularly sought feedback on the food offered to see if people were still happy with the choices available.

People were also supported to have their meals in their room if they chose. We saw one person had received their meal at the appropriate time. We spoke with the registered manager about this person as they were being monitored for their weight and had not eaten much of their meal. The registered manager told us the person was on food supplements which had been arranged in liaison with the GP. They told us although the person often chose not to eat they were maintaining their weight through these extra supplements but the registered manager emphasised it was an ongoing task. There was comprehensive evidence of detailed liaison between the GP, dietician and the home for this person. The deputy manager also told us that it was recorded how much people ate on a sliding scale where 1 was nothing and 4 was everything, and if required the dietician was requested. We looked at these charts and could see it was recorded that food was offered and refused at two hourly intervals; however, it was not recorded what was offered. The registered manager agreed to remedy this.

One relative we spoke with said "if there are any changes staff always tell us promptly, communication is excellent. Staff know how to deal with confused people – they are very skilled and I've seen it". Another relative also told us "There are no complaints about the staff. They do

Good

Is the service effective?

everything well. The way they work is good." Staff told us "the induction included the job role and everything that goes on. It lasted for three months and the manager had to sign things off".

We looked at staff records and found that each had a photo of the staff member on the front to aid identification. Each file also contained proof of identity such as a copy of the birth certificate and passport. There were also induction records which included a list of core activities to be completed over a period of eight weeks, mirroring the Common Induction Standards (which preceded the Care Certificate introduced in April 2015) which sets outs out the requirements for health and social care workers to meet. These were all signed and dated by both employee and registered manager. For staff in a more senior role there were specific additional training requirements including how to manage day to day difficulties in the service and discharge from hospital.

One member of staff told us they had supervision every two months as far as possible. They said it was used "If we have any concerns, if you have any problems, need training and to talk about what you want to do. I have done my level 2 and I am now doing my level 3 which I have to complete in twelve months." They also said "Yes, it is of benefit as you can say things you don't want to say in front of other staff."

We saw evidence that staff received regular supervision, usually six sessions a year. These sessions included discussions between the staff member and the registered manager about how someone was performing in their role, specific topics relevant to that individual such as how to support their colleagues for those in more senior roles. We also saw records of where staff had been observed in a particular activity such as infection control and where further training needs were identified. This had then been followed by the provision of the necessary training.

The annual appraisal round had just started for this year which a member of staff confirmed as they were preparing for theirs. The registered manager had recently sent staff their section of the form to complete and had arranged interview dates with them on completion. We saw completed forms from the previous year which showed staff were encouraged where they had performed well and they had the opportunity to raise any concerns.

Staff received access to regular training in a wide range of areas including the safeguarding of vulnerable adults, National Vocational Qualification levels 1, 2 and 3, health and safety, infection control, moving and handling, dementia awareness, the Mental Capacity Act and medicines where their role required this. Each course had a questionnaire showing what work had been completed and the level of understanding the staff member had obtained from undertaking this. Staff also had specific training in offering people choice and the many ways in which this could be facilitated, how to manage more complex behaviour looking particularly as diffusion techniques and the importance of respecting someone's privacy. Some of this training was through a national training organisation and other sessions were arranged in-house.

The deputy manager told us they were currently undertaking their level 5 National Vocational Qualification in leadership and management which had been encouraged and financially supported by the registered provider.

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 when this is in their best interests and legally authorised under the MCA. The application 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. We found that the home had three authorisations in place and they reviewed these decisions monthly to ensure they were still relevant and they were abiding by the conditions. They had also made other applications to the local authority as the Supervisory Body but were awaiting the outcome of these.

The registered manager informed us that all staff had received training in understanding the implications of the Mental Capacity Act 2005 and how this was to be used in daily decision-making. We saw that capacity assessments reflected someone's abilities such as "[Name] can retain some information given to them if a question is short and

Good

Is the service effective?

relates to the decision at the time, this fluctuates if they are tired. Staff need to speak slowly, loudly and clearly and let [name] respond." Where people did have capacity we saw that the home had sought their written consent for access of care records to be shared and consent to receive support with medication.

One member of staff told us "People have DoLS in place for their own safety apart from the ones who can make their own decisions." They continued "We assess whether they have capacity to make every day decisions or bigger decisions, and whether they can make these safely on their own. If they can't make it on their own, someone will do it in their best interest." They gave an example of guiding someone to make a decision such as "it's not warm outside so we would offer them a choice of warmer clothes." We asked the staff member what they took into account when making a decision and they replied "Even if a decision is bizarre they might have capacity to make this decision." This shows the home had a good understanding of the principles of the Mental Capacity Act as people are able to make unwise decisions. A different staff member said "I would always check facial expressions if a person can't speak" again following the principle of ensuring ever opportunity is given for an individual to make a decision.

One person living in the home said "the GP comes straightaway if I'm ill" and a visiting relative was keen to tell us that "the staff seem to notice issues really quickly and act promptly". Another relative said "they pick up on infections before they take hold" which shows the home knew people well. This was reiterated by a visiting health professional who told us "staff are extremely helpful. I'm in the home twice a week and the staff always ask who I am here to see. They ensure the next person is ready in their room when I need to see them. All the records are completed as needed and staff will react to any concerns efficiently". On a recent visit they had raised concerns about someone's knee and found staff had already contacted the GP to arrange a visit. We also found evidence of chiropody and optician visits amongst other health and social care professionals. This demonstrates the home were fully aware of people's specific conditions and responded in a timely and efficient manner.

Good

Is the service caring?

Our findings

One person living at the home said "They are really good girls. The staff are caring and are always nice. You can't fault them. If I ask for juice, they bring it. They pop a cup of tea in". While we were talking to this person in their room, a member of staff came in and asked them quietly if they needed assistance with their continence care in a kind manner.

As soon as we arrived at the home a person came downstairs and said "I'm cold. I must have left my cardigan upstairs." A member of staff duly supported the person to the lounge, ensuring they were settled before going upstairs to get it for them.

One relative we spoke with said "Staff can't do enough – they are spot on. Nothing is too much trouble and communication is excellent". They also said "I can turn up unannounced and often find staff sitting with her and being attentive." They also told us that they felt staff took pride in their work and people were changed if their clothes became stained for any reason, if the person agreed and that they often witnessed 'lots of banter and saw staff had a good rapport with people."

The visiting health professional we spoke with said "this is the most helpful home I visit. Staff are always happy to help". They also said that staff responded to any requests for extra support quickly and effectively such as supporting someone who kept removing a dressing from their leg due to their limited capacity but staff ensured that this was kept covered as much as possible to reduce the risk of infection. In another instance the health professional had expressed concerns that someone's trousers were too tight for their condition so staff replaced them with a loose fitting skirt with their agreement.

One person was discreetly asked if they would like to 'freshen up' before dinner and another person was becoming increasingly anxious that they were being left behind. Staff responded appropriately each time they returned to the room showing understanding of the person's distress. When they escorted them out of the lounge we heard them ask quietly outside if the person needed to use the toilet.

We saw that people were dressed in matching outfits and looked well cared for with nice jewellery and proper fitting footwear. We observed during the afternoon that someone was assisted to find the toilet due to their poor visual awareness by a member of staff. The staff member prompted where necessary and engaged the person in a conversation while helping. This showed the home displayed consideration for people as individuals and recognised their specific needs.

It was evident throughout the day that staff requested people's views as to what they needed through the questions they asked whether this was a drink, some activity or assistance with personal care which was always done discreetly. One person told us "Staff know me well. They know what I like." This same person later said "I help to get myself dressed as much as I can and staff help me with the rest." This was reiterated by a member of staff who explained this individual when "asked about their preferences will tell you." They also told us about how they communicated with people who had difficulties in this area such as ensuring questions are repeated clearly. This shows that staff were seeking people's consent to care interventions.

A staff member told us "We always explain what we are going to do and we always ask people to help as well. One person is unable to wash all of their body but we encourage them to wash the bits they can to keep that bit of independence. We always say 'is it OK if we do this?' before doing a task".

A relative told us "My relation is encouraged to be as independent as possible. Sometimes they have days when they say 'I can't stand, I can't walk' but staff always encourage them to get up." A staff member said the home was also keen to ensure people's cultural needs were met; "We have someone who is a practising Catholic and we have someone to come in once a month to give Communion."

The registered manager advised us that privacy and dignity was considered at every opportunity and staff were reminded in staff meetings. They focused on reminding staff to ensure people looked respectable and clothes were adjusted properly, that language was appropriate, that staff knocked on people's doors before entering. They also conducted regular observations and if issues were identified these would be dealt with promptly.

One member of staff told us "We always do personal care in private, making sure the windows and curtains are shut. We always knock before going into a room." They continued to

Good

Is the service caring?

tell us “We speak to people as an individual and address people how they want to be addressed.” Another told us if family visited they always try to ensure people had privacy to speak to their family. The same staff member said they respected people’s own preferences for privacy in the home and people could go where they wanted.

The registered manager advised us that all staff had recently completed training around end of life care. One staff member said this had included “how to keep people comfortable at the end of their life. Our priority is the resident.”

Good

Is the service responsive?

Our findings

A relative told us their relation had "been in the kitchen before as they love baking. They're not into arts and crafts so they let them help out with other things like ingredients. Baking is the only thing they like to do." They also told us that some rugby players visit the home and throw the ball around and their relation says they're not interested but then they have witnessed them joining in. Another relative said "the home has staged a 'clothes fashion show' before where people could choose items of clothing to buy". The relative felt this was an excellent opportunity as not everyone could go out and purchase their own, relying on care staff or family to do it for them.

When we arrived at the home we found nine people in the lounge, three were asleep. However, one person was also going out for their daily walk with a friend who visited regularly. We asked staff what activities were on offer for people to join in. On staff member told us "We try to do a lot – bingo, watching films, Michael Ball singalongs, nail care and we play games. We have enough activities to do but not always enough hours to do them." Later we saw people engaged with a DVD of Daniel O'Donnell singing.

There was a poster advertising the forthcoming Halloween event, which the registered manager said would also involve people decorating buns, and the staff member said "We have a singer and a couple of lads who came in to do armchair exercises. They all enjoy it. I like to play skittles with people." We also saw reminiscence boxes in each of the communal areas containing items such as balls of wool, tea cosy and tea strainer. The registered manager said they had a 'reminiscence quiz' on order as people liked these. There was also a display of vintage posters on the wall illustrating common pastimes relevant to people's lifetimes such as sequence dancing, skipping, and hopscotch.

We asked staff how they knew what people liked. One staff member told us "It's all documented in the care plan, including life histories and what they would like to happen." The staff member said that they had gained an understanding of people's needs through working with them and learning about their likes and dislikes. They said "we make sure at mealtimes people are given a choice, always asking people if they want their medicines, what they want to wear."

We found care records contained photographs and a person's preferred form of address. They also included 'needs at a glance' so that staff could quickly gain information about someone they were caring for. In one person's records we saw it noted "I don't care for orange juice" and "When I'm feeling anxious, I like to chat about it". In addition there was a section termed 'What I can do well' and in this it indicated "I can do small tasks for myself if you encourage me, like my hands and face". This reaffirms that the home were keen to encourage people to be as pro-active as possible.

We saw detailed life histories which contained information about a person's early life, parents and education, career, work and achievements. Prior to admission people had had an initial assessment to ease their transition into the home. After admission these preliminary care needs were evaluated at two weekly intervals.

Staff were able to give detailed information to us about people in the home demonstrating that they knew their needs well. This was reflected in people's care plans which showed people's interests and where they had specific needs that needed more specialist help such as input from external health professionals. For identified support needs such as bathing or mobility, needs were discussed in depth and showed how people preferred them to be met. For one person we saw "Staff to continue mobility and exercise programmes as per mood and fatigue" to ensure they were following input received form the physiotherapist but in line with the person's wishes and abilities. In another record it was noted ""Talk to me like I am your equal. I have my own opinions and thoughts. Treat me with respect". We observed staff talking to this person later in the day and found them to following this well.

In addition to this detail for the needs a regular two hourly recording sheet was kept showing what a person had been doing during the day including whether they had eaten, chatted or joined in any activity. We saw that people's weight and pressure care was recorded appropriately and in a timely manner.

One relative explained how they were involved in care plan reviews. These gave the opportunity to consider "if there was anything else the person needed or needed doing, and to discuss how they were getting on." We also saw evidence of in house reviews which were completed every two months where questions such as "Do staff always knock on your door before they enter? Do they ask your permission

Good

Is the service responsive?

before helping you with your care needs or your medicines?" were asked and people replied positively. The same review also asked "Do staff your care and support needs with you? Again the answers were positive.

The registered manager explained the system for shift handovers which included both written and verbal feedback. Key information was recorded relating to each person and staff were expected to read this at the start of each shift. There was a specific medication communication sheet for any alterations to medicines. They were stored in a large file which also contained the staff newsletter which was issued monthly and the daily notes for each person which were filed once completed.

We saw evidence of many compliments including a recent one from external health and social care professionals who were impressed with the high standard of care home had shown to a person being assessed. It referred to the comprehensive and well written care plan which helped key personnel find the relevant information quickly. This was endorsed by a member of the person's family who said the home 'had always shown their relative respect and maintained their dignity'.

The home had only received one complaint in the recent past and this had been dealt with promptly by a face to face meeting with the concerned relative and the matter resolved immediately by explaining that the home had been following the person's wishes but acknowledging the upset this had caused the relative. We saw evidence of many compliments including one from a visiting social worker who had highlighted how comprehensive and well written the care plans were which aided their assessment and who had fed back from the family of this person how much they had appreciated the respect and dignity shown to their loved one.

Good

Is the service well-led?

Our findings

One person told us "The manager is a little gem. They are nice and kind. I stretch them to the limit." A relative said "As long as my relation is happy and content that is all we care about. They would tell us if they were not happy. We've taken them out when we can and then they want to get back. They can't be late if someone is singing as they love that." They also told us "The manager is a very good leader. They are always there, helpful and will help with forms. They are always at the end of the phone. It's a lovely atmosphere and my relation has really settled."

One staff member said "I love working here. I worked in another care home before and it wasn't anything like here. This home is well run by the manager." They also told us the registered provider is very involved as they do all the maintenance. The visiting health professional told us "It's a friendly and homely home."

There was a registered manager in post on the day of inspection. 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.

We asked staff what values underpin the home and one member told us "Letting each resident be an individual and they are as well cared for and looked after as they can be." Another said "To treat people with dignity and respect and provide a high level of care."

We asked if staff felt supported in their role. One said "Yes, I feel listened to. Staffing levels are brought up at staff meetings but they tell us the staff ratios are right. The staff take it on the workload rather than the ratio as some people take time to be cared for." However, they went on to say "the manager is brilliant. You can say anything and they will help you as much as they can. They are here Monday to Friday, at weekends a senior is in charge. The manager is very focused on what needs to be done and doing things right."

Another staff member said "There is very supportive management. I know I can go with any problems. This is the same with the registered provider as evidenced when the manager was of for a while as the registered provider would often come and support me." They also told us "I enjoy the job. There is good team working and it's a happy place to work. I've been here eight years." The deputy manager said "Staff are always happy to help. Visitors are always offered a cup of tea when they come."

We saw evidence of regular staff meetings for particular staff groups such as night staff with very specific discussions. Any issues raised from these were then shared on the staff newsletter so that all staff were aware. These included reminders for staff to record portion sizes on food charts and to mark eye drops and creams with the date opened. Later meetings included topics such as the importance of obtaining capacity and consent and what staff should do if someone said they were an inspector! These were stored with the daily records so that staff on each shift could access the information as needed.

These newsletters also referred to areas where staff were performing well such as managing pressure care effectively, ensuring handovers were fruitful and passing on concerns. They equally mentioned areas where staff needed to improve such as offering people more opportunity to have showers and promoting activities with people without being prompted. It was obvious that the registered manager had clear expectations for staff conduct and was scrutinising their performance in all aspects of their role, dealing with any issues promptly but also praising staff where high performance was observed.

We saw that medicines were audited weekly and also monthly, the last one dated 9 October 2015. No issues had been identified. There were also daily, weekly and monthly checklists of tasks to be undertaken by care staff which were to be initialled once completed. Some of this was to ensure infection control measures were being adhered to. Each audit tool had a section for issues outstanding from the previous month, actions that needed remedying and future recommendations including how this information was to be relayed to staff. These were duly completed and showed the home took appropriate action to resolve any issues promptly. In addition, there was detailed quality assurance audit form August 2015 which had developed action plans including individual care delivery, staff training and support, information sharing and health and safety.

The registered manager completed a monthly feedback sheet to the registered provider detailing key issues and events around people's care needs, staff issues and relative feedback, It included feedback on infection control,

Good

Is the service well-led?

medicines, health and safety and showed a quality assurance framework that had recently been drafted to include monthly feedback from both people living in the home and their relatives. There was a plan to introduce a monthly feedback sheet for staff as well. This was collated through all the other checks that had been ongoing throughout the month, ensuring that nothing was missed.

We found evidence of relative feedback from August 2015 which was mostly positive. One person said "It's very good here" and another said "My relative is very happy". The only issue raised by one person was that sometimes people's clothes got mixed up.

We saw that the home had policies and procedures in place in regards to safeguarding, accidents and post fall monitoring and nutrition and other key aspects of the management of the home. These had all been reviewed on a six monthly bases, many only in August and signed by the registered manager. There was also a staff signature sheet which indicated which staff had read the policies.

The home was undergoing extensive refurbishment on the day of our inspection but this was being handled in a planned and safe manner. The registered provider was the lead builder so they were fully aware of the difficulties facing the home. We saw the registration certificate on display in the hall area. We saw that equipment such as the bath lift had been tested recently and appropriate certificates were in place.

One staff member said they felt a quality service was "one where you just make sure people are well looked after. The manager is always researching good practice and does a newsletter on how things are progressing in different aspects of the job. We are always reminded about policies and procedures, and they make sure we know about them." The deputy manager said there was also regular observation of staff practice by the registered manager to check for quality of performance in addition to their presence around the home during the day in addition to the registered manager checking the premises daily. These observations included looking at care of people in the home, privacy and dignity, meals including preparation and support for nutrition, communication and care records. Any issues were logged, raised with the individual member of staff and if a home-wide issue shared with all staff as a general topic.

One relative told us "I think they would take notice of any suggestions. However, I've never needed to raise anything." People's views were sought via residents' meetings which were held monthly.

The registered manager was fully aware of the issues some staff had raised with us about staffing levels without us prompting them and advised us they were very keen to ensure they recruited the right staff for the home. This meant that the recruitment was not as fast as some people would have preferred but they felt they were looking after the interests of the people living in the home which was their priority. They told us "I am constantly looking at how we can improve and I know I can never know everything."

We asked the registered manager what they felt their key achievements were and they said "a good staff team who do their best for the resident. We try to make life as happy as it can be for people. We want to make families feel reassured that their relatives are looked after and they can sleep at night. I observe every morning and help out where needed so I think I provide a good role model for staff." This was evidenced throughout the day of our inspection as staff were knowledgeable and approachable, ensuring that people's needs were met promptly and with respect. The registered manager demonstrated these values in all their interactions with both staff and people living in the home, showing effective and rigorous leadership.