Little Sisters of the Poor

St Anne's Home - London

Inspection report

Little Sisters of the Poor, St Anne's Home
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London
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected St Anne's Home on 25 July 2016, the inspection was unannounced. Our last inspection took place on 29 July 2013 and we found that the provider was meeting all of the regulations that we checked.

St Anne's Home provides accommodation for 32 people who require nursing or personal care. The home is situated in the town of Stoke Newington and close to community facilities. At the time of our inspection there were 30 people living at the home.

Accommodation was provided over three floors and offered comfortable and spacious facilities. There was a number of independent flats attached to the home including separate living quarters for the Sisters. The aim of the provider is to offer the highest quality of care and security for older people, taking into account the particular conditions associated with the ageing process.

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.

Staff had a clear understanding of safeguarding and whistleblowing procedures and had received training on how to protect people from harm.

Risk assessments had not always been followed in relation to the environment to ensure that they were always protected from avoidable harm. People's healthcare needs were assessed to show how risks should be minimised and staff adhered to the guidelines.

The provider had the appropriate systems in place to ensure medicines were managed safely. Staff had received the required mandatory medicines training.

People's nutritional needs were met and any dietary needs were managed appropriately. Special requests by people were included in the menus.

Good systems were in place to assess the suitability of the staff employed. Sufficient numbers of staff were available to meet people's needs in a timely way. Staff shared their knowledge and information on specific areas of training.

People were involved in decisions about the care they received and told us staff were kind and caring. People's needs were assessed before they moved to the home.

Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People had access to a wide range of activities that were both individualised as well as meaningful for people. People's religious, cultural and social needs were met and their wishes were respected and valued.

Reasonable adjustments were in place to support people with their healthcare needs. People were supported to maintain good health and to obtain treatment when required. Healthcare professionals spoke positively about the service.

Spacious well-equipped facilities were available to people and their privacy and dignity was respected. There was an effective transitional process in place for people when they were referred into the home.

Staff were well supported by the registered manager and enjoyed their work together as a team.

People's views were sought on how the home was managed. Complaints had been responded to appropriately when they were raised.

The registered manager and provider had quality monitoring systems in place, which helped ensure that all areas of the service were working well. However, these were not always effective as they had failed to identify that staff were not always following an environmental risk management plan.

We have made one recommendation relating to safe care and treatment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Elements of the service were not always safe.

Environmental risk assessments were not always followed by staff. Risk assessments were completed with reference to people's specific healthcare needs.

People told us they felt safe in the home. Staff were trained to protect people from the risk of abuse and knew how to report concerns.

There was a sufficient number of staff on duty to meet people's needs. Safe recruitment practices were followed by the provider.

Medicines were stored, recorded and administered in a safe manner.

Is the service effective?

Good

The service was effective.

Staff competence was routinely checked to ensure they had the required skills and knowledge to meet people's needs.

Staff understood the Mental Capacity Act 2005 and applications for Deprivation of Liberty Safeguards (DoLS) authorisations had been made where restrictions were imposed to keep people safe.

People received support with their nutritional needs and were offered choices of their preferred foods.

The service worked with health professionals to ensure people's physical and mental health needs were met.

Is the service caring?

Good

The service was caring.

People told us they were treated with respect by kind and caring staff.

People were involved in the decisions about their care and their

opinions and views were listened to and valued.

There were beautifully decorated areas of the home where people could relax. People received care in a dignified and private manner.

Is the service responsive?

Good

The service was responsive.

People had access to a wide range of activities to encourage their independence and nurture their wellbeing.

The religious, cultural and spiritual needs of people was recognised and valued.

People were given information on how to raise complaints and knew whom to speak with if they had any concerns.

Is the service well-led?

Good

Aspects of the service were not well led.

There was a system of quality checks to ensure that people received safe and appropriate care and support. However, these had failed to identify that staff were not always following an environmental risk management plan.

People felt supported by the registered manager who had a good management oversight of how the home was run.

Staff spoke positively about the registered manager and told us they enjoyed working in the home.

St Anne's Home - London

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 25 July 2016 and was unannounced. The inspection team consisted of two inspectors 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, the provider completed a 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 they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the PIR, previous inspection reports and notifications sent to CQC by the provider. The notifications provided us with information about changes to the service and any significant concerns reported by the provider. We also contacted the local authority and spoke to one health and social care professional to obtain their feedback about the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people who used the service, the GP, two nurses and a visitor of a person in the home. We spent time observing the care people received and toured the building.

Additionally we also spoke with the senior care worker, three care workers, the activities co ordinator, the administration and finance officer, the assistant manager and the registered manager. We looked at the records in relation to four people's care including their medicines records. We also viewed five staff recruitment and training records, minutes of meetings with staff, quality assurance audits, complaints, staff rotas and some of the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People may have been at risk of avoidable harm as staff did not always follow written guidance in risk assessments about how to manage potential risks in the environment. During a tour of the building, we saw there was a large balcony with seating areas overlooking the car park. We looked at the risk assessment for the balcony which clearly stated that the balcony doorways must be kept closed, however it also stated that people with cognitive impairment were closely monitored during the day and night to help minimise any risks. There was one person on the balcony on their own during the inspection and the assistant manager told us the person did not have any cognitive impairment and was not at risk. However, we saw that the door was left open at the beginning of the inspection and at the end of the inspection, which meant that staff were not following the provider's risk management plan in relation to the balcony. The provider told us that there was no one living in the home at the time who would be able to climb the balcony and therefore be at risk of falling. We recommend that the provider seeks advice from a reputable source about mitigating any risks posed by the balcony.

We discussed this with the assistant manager who agreed to follow the preventative measures outlined in the risk assessment and review this. They also stated that they would consider fitting a door sensor to alert staff when people had accessed the balcony if this was assessed as appropriate to protect individuals and for people to be closely supervised by the staff to help keep them safe.

All the people we spoke with told us they felt safe and supported living in the home. One person told us, "Yes I feel safe, I don't feel otherwise" and another person said, "Absolutely safe, they lock up at night, I'm a human being and they treat me like one." Other people's comments included, "Yes I do feel safe I'm used to it here, I was one of the first to come here", "Yes I do, they are very kind in here," and "Oh yes totally safe, they're so good to you here."

Assessments to minimise the risk of people falling had been completed, which included actions for staff to take to reduce the risk of harm or injury. We also saw that staff took appropriate action when they were concerned about a person's welfare. For example, we saw that one person had been referred to a falls clinic by their GP and was seen by a physiotherapist. Another person had a specific plan in place that included a floor sensor to alert the staff if they had any falls; a night time routine had been developed to keep the person safe and daily records showed that this was followed. Staff had received training in falls prevention.

Risk assessments were regularly reviewed and related to assisting people to mobilise, the risk of malnutrition, pressure sores, lack of social stimulation and bed rails. Risk assessments had been developed to minimise risks and these were understood and followed by staff. For example, we saw completed monthly assessments on how to move and position people safely and for one person we found pictures to guide staff on how best to position the person in and out of bed.

Additionally, risks were assessed where people had attended activities in the home and in the community. There was a comprehensive plan in place for the use of the sewing machine that was located in the arts and crafts room. This advised staff that needle guards must be used and people supervised and supported

during the activity. The home had access to a minibus so people could take trips out in the community and we found that staff drivers' licences were regularly checked to certify they could transport people in the minibus safely.

People were supported by staff who could explain how they would recognise and report abuse and records confirmed they had received training on how to keep people safe from harm. One member of staff we spoke with was able to explain that if people at risk of developing pressure sores were not turned regularly in bed, this may result in harm to people's skin and how this would be treated as a safeguarding concern as it would be considered neglect. Another care worker described the guidelines they would follow if they found injuries on a person's body and whom they would report this to. Records confirmed the provider had systems in place to report any concerns to the appropriate authorities.

Staff were familiar with the whistleblowing policy that gave clear guidance and advice of who staff could report to in the event of any concerns they wished to raise in the workplace. The contact information included the provider, the CQC and other public organisations. Employee handbooks directed staff to the bullying and harassment policy if they had concerns regarding staff conduct in the home so that this could be addressed.

There was a sufficient number of staff on duty to meet people's needs. To support people safely in the home we saw that call bells were placed in people's rooms and were in easy reaching distance in the event of any emergencies. People told us, "I have used it but not very often but when I have they come very quickly", "I've used it and I've called them at night and usually they arrive quickly," and "I have one in the bathroom and one in the lounge and one by my bed and when I use it they come within five minutes."

The provider employed their own bank staff to cover staff absences. Care workers told us that a number of staff lived within walking distance of the home, and if the registered manager required additional cover they were able to accommodate this. The nurse on duty said, "We have enough staff and we work together as a team." We looked at the staff rotas and found staffing levels were consistently maintained.

The provider followed safe recruitment procedures and carried out background checks on staff before they began work to ensure they were suitable to work with people using the service. We looked at staff files and found application forms, job descriptions, two references from previous employers, identification checks, and interview questionnaires that were checked by the registered manager. Staff were given job descriptions so they were informed about the responsibilities of their roles. Criminal record checks were carried out on all the staff.

The arrangements for the management of people's medicines were safe. People told us that staff explained what their medicines were for before administering them. Two people reported, "I know exactly what I'm taking, I self-medicate and I will do that as long as I can for my independence, they have told me about the side effects but I don't suffer from any of them "and "I take medication, I know what it is and I know what the side effects are."

We checked the medicines administration records (MAR) with the nurse on duty and found that staff had followed each step of the administration process. Staff signatures and initials showed that these corresponded to the medicines entries. The nurse explained what people's medicines were prescribed for and we saw where people had refused medicines this was accurately recorded. There was a temperature-controlled room where the fridge was used to store some medicines. We saw that medicines were stored at the correct temperature and this was checked regularly. Pain assessment charts had been completed to ensure that people's pain was managed and their records detailed the reason 'as required' medicines were

administered and these were reviewed monthly. There was a lockable cupboard for the storage of controlled drugs and a Controlled Drugs (CD) register. The CD register showed the correct entries for controlled drugs and had been signed by two nurses. The returns medicines book demonstrated that any surplus medicines were disposed of safely. The nurse explained that all staff were given annual refresher training and medicines competency checks and we saw records to confirm this.

People's safety was maintained through the maintenance and monitoring of systems and equipment. We saw that regular servicing was carried out on fire, gas, water and electrical equipment such as hoists and lifts. This was monitored by the maintenance staff and checked by certified external contractors and equipment was in service date and clearly labelled. Maintenance forms were completed monthly to make sure wheelchairs were safe for people to use. Fire evacuation drills were regularly held involving both people who lived in the home and the staff, and people had personal emergency evacuation plans written plans on how they should be supported when leaving the home in the event of a fire.

The home was immaculate and free from malodours. We saw in the minutes of the staff meeting records that staff they were advised to read the handling of clinical waste policy. We found the policy had been followed and staff had completed infection control training. There were large separate rooms for the storage of mobility equipment, laundry and clinical waste and the areas were clean and well maintained.

Good

Is the service effective?

Our findings

Staff had access to the training and support they needed to carry out their roles and meet people's needs effectively. Staff told us they had completed an orientation programme before starting work. The programme included a comprehensive checklist to make sure staff were inducted into all aspects of care provision. The training records we looked at showed that staff had received training in fire safety, basic life support, health and safety, stroke awareness, moving and positioning, food hygiene, first aid, wound management and a recognised national vocational qualification in health and social care.

The provider employed their own trainer who regularly assessed staff competencies and supported them to keep up to date with best practice guidance. Staff received regular supervision, which encouraged them to maintain good standards of care and identify areas for development. For example, we saw that staff had been given the opportunity to take on new roles when they expressed an interest in doing so.

The registered manager held yearly appraisals of work performance with care staff to review their personal development and competence. Regular team meetings took place to give staff the opportunity to discuss best practice regarding how to support people and any areas of concern. Information was shared and learning highlighted to improve how the service delivered care. One care worker had attended a training session on supporting people with Parkinson's Disease and fed back to the team what they learned and described the training as a "very positive" and "enlightening" experience. Care workers were given booklets after the feedback on how to care for people with Parkinson's. This demonstrated that all staff were able to learn from their colleagues by sharing their knowledge from specific areas of training.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and saw records to show that where people had been deprived of their liberty applications had been made to the local authority and best interests meetings had taken place in line with the MCA. We saw there was a DoLS checklist in place for staff to follow who confirmed they had received training in this. Best interests meetings were held where it was felt that individuals were unable to make specific decisions about their care in areas such as their nutritional needs and medicines. Documents in people's care files showed where they had a lasting power of attorney (LPA) for their finances or health and welfare. An LPA is a legal document that lets people appoint someone to help them make decisions or to make decisions on their behalf. We also found that the staff and healthcare professionals, for example, the GP, had completed capacity assessments to help ensure that people's rights were protected.

The staff obtained people's consent before carrying out any aspect of care and relatives had been involved in decision making where appropriate. For example, assessments of people's needs included discussions with relatives and health and social care professionals. Consent forms had been signed by people to have their photographs taken and displayed in the home and for staff to support people with their medicines.

We asked people for their comments about the food and drinks they were provided with and they said, "Not bad, fairly good choice my favourite meal is breakfast. At night if I get hungry I can go into the kitchen and make myself something." Another person said, "Yes the food's good we get a choice, the day before they come around with a menu, I don't have a favourite meal I eat anything really and at night I have water and biscuits by my bed." Other people echoed this, "We get a good choice of menu and they make a great steak and onion pie which is my favourite meal. We have a book here telling [staff] what you don't like, at night I have snacks and water that I keep in my fridge", "I'm amazed how good the food is, it's excellent, breakfast lunch and supper" and "It's a God send that you don't have to cook it."

Meal times commenced with a priest who also uses the service saying a gentle prayer of Grace before the meals were served. We saw that staff and some people in the home took part. People were supported to have a balanced diet and were involved in menu planning and we saw records to show that people's preferences were discussed in the residents and staff meetings. We observed staff offering alternative food options if a person did not want what was available on the menu. Everyone was offered a choice of drinks throughout their meal, care workers encouraged people to eat and they were offered extra portions of food. The menus included a range of healthy foods including fresh fruits and vegetables.

Special requests by people were included in the menus, such as fish and chips, cheese, beetroot and crisps. People's nutritional needs had been assessed and recorded in their care plans. Food trays had colour-coded labels that showed people's dietary requirements, for example, soft diet, gluten free and requires assistance. Where people had difficulty with eating, drinking or swallowing referrals were made to the speech and language therapist (SALT) for an assessment of their needs. A visitor of a person in the home reported, "The food is good, the chef came up and asked everybody what their likes and dislikes are. I brought in some black pudding and they cooked it for [my friend], there's a good choice."

We observed lunch and found there was a positive atmosphere, which made mealtimes an enjoyable and relaxing experience. Where people required support to eat their meals staff were caring, patient and discrete. One care worker was listening and speaking to the person they were assisting with their meal and they enjoyed good humoured and warm exchanges between each other. People socialised with each other throughout the meal, and asked staff questions who readily listened and responded to their requests. Hand written cards were placed on people's trays with their food preferences and dining tables were nicely laid to help show people they were valued.

People told us they had access to the GP who visited the home weekly to support them with their healthcare needs. Care records contained details of attended healthcare appointments and any input from health and social care professionals. People were weighed on a regular basis to identify if they were at risk of malnutrition and to ensure they maintained a healthy weight. Specialist equipment such as pressure relieving cushions and mattresses were provided to people and turning charts were accurately completed to ensure effective pressure ulcer prevention. We found that where people had diabetes there were diabetic management plans in place that were being followed. Staff were knowledgeable about the physical health needs of the people they supported. The GP we spoke with was complimentary about how staff responded to identified healthcare needs swiftly and followed the appropriate healthcare guidelines, and commented it was the best care home they had provided GP services to.

Good

Is the service caring?

Our findings

We observed staff communicating with people in a very kind and compassionate way, offering choices and involving people in the decisions about their care. During meal times, we noticed a person seemed unsettled and the care worker asked if they would like to be taken for a walk in the garden after their meal. The person's face immediately lit up and their demeanour immediately changed to a cheerful disposition. One care worker said, "The best thing about working here is that we see people smiling."

We spoke to one person who had arrived back home after being discharged from hospital. They told us they were greeted warmly by the staff on their return, "They gave me such a lovely welcome back, also the physio came this morning and tried to make me run a marathon, the home is lovely not only the residents but the carers, they are very humble and respectful." Where another person had been admitted to hospital we saw daily records that showed staff had contacted the person's family members at the hospital on the same day to check on their wellbeing.

Several compliments had been received from people who lived in the home and their relatives and comments included, 'Thank you for looking after my [family member] so well, we are able to see her/him at 100 per cent', 'Thank you for the kindness hospitality and prayers' and 'Thank you for the care, you made my day extra special with the magnificent birthday cake'.

People told us they were treated respectfully by kind and caring staff who always knocked on their door before entering. One person said, "They do knock on my door, I was amazed they treat me with so much respect and kindness." We saw staff knocking on bathroom doors asking if people needed any assistance prior to entering. If someone needed assistance with their personal hygiene we observed staff asking discreetly and sensitively, gently guiding people to the appropriate facilities.
There were areas in the home where people could peacefully relax and speak to their relatives, friends and staff privately. On the ground floor, there was a large library with an assortment of books, videos, DVDs, jigsaws and a computer for people to access the internet. Reading materials were accessible in large print to ensure the information was easily understood by the people who lived in the home. Clear written signs were placed in hallways and on doors to help people with their orientation so they could identify and locate areas of the home with ease.

We viewed a bright modern smoking room furnished with warm comfortable seats. Natural light shone through the large windows in all the rooms and the home had a spacious tea room that welcomed visitors and relatives for coffee and tea. The tea room had expansive patio doors that opened out onto a vast neatly maintained garden with shaded seating areas and garden benches. Access to the garden was unrestricted and accessible for people who used wheelchairs. One person reported, "I can go where I like in the home and the garden." On the second floor, we saw there were quiet corners with seating and one was furnished with a grand organ. The registered manager told us people could play this if they wished.

People were involved in decisions about the care they received and were offered choices based on their specific preferences. For example, the home had a medical suite and people were given the choice to be

visited by the GP in the medical suite or their own rooms. Additionally people were given the choice to remain registered with their GP or be seen by the visiting GP. In one person's file, we saw they were involved in completing a social assessment of their interests and hobbies. Other care files we viewed outlined people's personal preferences regarding their preferred daily routines. One person preferred to be supported with a shower instead of a bath and another person had chosen to spend the day in bed. This demonstrated that people's wishes and preferences were recognised, valued and respected.

Advanced care wishes were written in people's care plans about how people wished to be supported with their end of life needs and evidence of discussions was recorded. These were regularly reviewed to make certain people's wishes were met. Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were in place for individuals where appropriate and we saw evidence of discussions with multi-disciplinary teams and people's relatives to ensure that people were consulted about important decisions about their healthcare needs.

Good

Is the service responsive?

Our findings

People talked to us about the activities they attended and what they liked to do. One person said, "I go to the supermarket, I get there by dial a ride", a second person explained "I like to walk but I also like singing and I like bingo" and a third person commented, "I sit and watch TV and do drawing." One person previously worked as a dress maker to a member of the royal family and said they were a prolific knitter, other people commented favourably about the person's knitting skills and told us they were the best and the quickest in the home.

People were offered a range of activities and accessible facilities throughout the home, to promote their independence and wellbeing. There was a shop situated on the ground floor that was run by volunteers and sold stamps, cards, snacks and an assortment of toiletries. Volunteers also helped people at mealtimes and assisted in the reception area. We saw that volunteers gave general help, laying tables, handing out fresh paper napkins between courses or fetching pitchers of juice. The assistant manager explained, "It gives people a sense of purpose."

One person told us, "They call me the resident artist and I love painting, I knit and go down to the arts and crafts room." The arts and crafts room was open daily and held a window display of colourful knitted jumpers that people had made in the knitting group. The room had an array of materials for people to work with including soft toy kits and a sewing machine. A brightly coloured budgie was perched by the window in an ornamental cage. Pictures of the knitting group were displayed on the wall and the assistant manager told us how people loved to socialise in the room.

The activities available were organised by the activities coordinator who held sing-a-longs, bingo, quizzes, social afternoons, outings, barbeques and gentle exercises. The provider employed a sessional physiotherapist to come in and support people with physio classes using specialised equipment. A hall was equipped with a TV and video projector with a large screen for people to enjoy movies. A hairdresser and an aromatherapist were available to help people maintain their personal appearance and improve people's well being. We spoke to the activities coordinator who had held a residents' meeting and reported, "The activities are flexible. I really like to get to know the residents we work with, I have just shown them an example of the newsletter I want them to help me with so they can tell me their life history's which we can publish for them if they wish."

People using the service and relatives could attend regular meetings where they could raise any concerns. One person said, "We have a residents' meeting and I attend them, they do listen as we are having a change of lunch time menu." Information was also shared at these meetings. For example, up and coming events, giving people the opportunity to discuss what was going on and make suggestions. We saw that people's suggestions had been acted upon in relation to daily activities and the care they received.

Staff supported people to meet their religious, cultural and spiritual needs and people could attend a place of worship of their chosen faith. Located in the home was a chapel for people to pray, attend mass, and evening prayers throughout the day. Overlooking the chapel was a large open gallery that people could use

to watch the ceremonies and attend rosary prayers.

Members of other denominations or faiths were welcomed to the chapel if they wished to visit. People from different faiths and people of no faith had chosen to live at the service, for example people who were Muslim, Hindu, Sikh, Jewish and Buddhists. Records showed that a priest had visited the chapel from Uganda, which reflected the provider's multicultural approach to meeting people's needs. For people who were unable to attend the chapel due to their mobility needs the home had installed a television link to enable those who wished to participate enjoy the service from the comfort of their own rooms. One person said, "I like writing letters and going to mass, I never get bored."

Reasonable adjustments were in place for people who lived in the home in order to respond to their individual needs. There were specialised baths, hoists and equipment for people to use throughout the home. A loop system had been installed for people who were hard of hearing and information on organisations that could help people with their healthcare needs were displayed on noticeboards. There was a cross gender and intimate care policy and staff were trained on the awareness of gender issues to ensure that people were appropriately supported.

Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. Care plans were detailed, personalised and reviewed regularly. Records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one assessment included information about whether the person's family would like to be contacted during the night, and the person's wishes to attend a place of worship.

People told us that if they had a concern, they would speak to a member of staff or the registered manager and felt confident their concerns would be dealt with satisfactorily. People commented, "Well that hasn't arisen really but if it did I would talk to the Sisters", "I have never made a complaint but if I did I would speak to the person if I can't get to them, the Sisters," And a visitor reported, "As far as I know he/she or his/her family have never made a complaint." People's information packs about the home gave clear guidelines on the complaints procedures. Any complaints raised by people had been actioned and responded to in a timely manner. The registered manager told us they had an open door policy and encouraged people to raise any concerns immediately.

Good

Is the service well-led?

Our findings

People told us they would not change anything about the home and a visitor explained the home was well managed. People said, "I'm happy here I wouldn't make any changes ", "The Mother and the Sisters and the staff do a good job and I can talk to them", "I wouldn't change anything here, they're very good to us" and a visitor commented, "The home is very well managed there's always someone repairing something or other."

There was a commitment to ensuring there was a phased move on strategy for people living in the independent flats. We spoke to two people who had moved from the providers' independent flats on site and into the home. They explained they had difficulty remaining independent and had moved into the home which had been a "blessing" as they knew the staff and the people that lived there. This showed that staff had a good understanding of people's needs and could develop positive relationships with the people they were supporting.

The registered manager monitored the quality of the service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care including care planning, medicines and incidents. However, we did note that staff were not always following risk management plans in relation to the environment and this had not been identified as part of the quality monitoring process. There was a health and safety consultation completed in April 2016 which analysed the number and nature of incidents and accidents. This identified issues such as staff training and the use of personal protective equipment (PPE). The provider employed a development advisor to provide updates and discuss any actions that needed to be addressed when carrying out quality assurance monitoring visits.

Staff gave positive comments regarding the views on the home and how this was managed and said, "They are doing a brilliant job, they put in 110 per cent into everything they do and put people first", "The residents and the environment, it's really nice working here, the staff are like my family", "I have a great relationship with the manager" and "I like everyone, I especially look forward to coming into work."

All the staff were consulted regarding any new and recent developments to the service in team meetings, such as advanced decisions and discussions with the GP regarding Coordinate My Care. Coordinate My Care is an NHS clinical service that shares information between healthcare providers and records people's wishes about how they would like to be cared for.

The registered manager told us their key achievements were "Treating them as individuals and offering a compassionate and caring service." We saw that a satisfaction survey had been sent to 31 people and 23 questionnaires had been returned. All the comments were positive about both the staff and the home. Where suggestions and feedback from the survey identified concerns, clear actions were implemented, for example, new fittings and fixtures requested in a person's room. We saw there was a comments and suggestion book in the dining rooms and a new trail menu had commenced.

The registered manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they

occurred.