Bupa Care Homes (Bedfordshire) Limited

Ridgeway Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 May 2016 and was unannounced. When we last inspected the service in February 2015, we rated the service as 'good' in each of the areas we looked at. However, we had to re-inspect the service earlier than planned because we had received concerning information that showed an increase in the number of incidents where people's needs had not been met safely.

Ridgeway Lodge is a residential care home in Dunstable, providing accommodation and support for up to sixty-one older people. At the time of our inspection there were sixty people living at the home, some of whom were living with dementia.

The home did not have a registered manager in post from December 2015 because they had moved to another location within the BUPA brand. This was a breach of the condition of registration that the location must have a Registered Manager. As a consequence of this the service has not been able to sustain the quality of care delivery or continue to make improvements seen at the last inspection on 23 February 2015. A new manager had been appointed and they were going through the application process to become the registered manager of the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People or their relatives had been involved in determining the way in which people's care was to be delivered, and their consent was sought before care was provided. However, the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards were not always met. We found that some people had been assessed to lack the mental capacity to make certain decisions, but the provider did not carry out best interest decisions meetings in line with the MCA.

People were safe living at the home as the provider had effective systems in place to protect them from avoidable harm. Staff were trained in safeguarding people and they understood the process they needed to follow, if there were concerns about people's safety. People's care needs had been identified and care plans that gave staff guidance on how best to support them put into place. There were risk assessments in place for each person and for the home environment, in order to minimise and manage risk effectively. People's medicines were administered safely however, we found gaps in one person's medicines administration records. They were supported to access other healthcare services to maintain their health and well-being.

The provider had a recruitment policy in place to ensure staff that were employed to the service were suitable to work with people who lived there. There was a sufficient number of skilled and qualified staff to meet people's care needs. They were trained in areas that were relevant to their role, and they were supported by way of regular supervisions and appraisals.

Staff demonstrated a kind and caring attitude towards people and provided care that was consistent and

person-centred. The home had a pleasant atmosphere where people's friends and relatives were encouraged to visit and spend time with them. People were treated with dignity and respect and had their right to privacy observed. Their dietary needs were identified and the service offered them a choice of food and drink based on their individual preferences.

The provider had a formal system for handling complaints and concerns. They encouraged feedback from people and acted on this to improve the quality of the service. They also had an effective quality monitoring process in place to ensure they were meeting the required standards of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The provider had a recruitment policy in place. Out of the six staff records we reviewed, one's lacked evidence that demonstrated their references were provided by a genuine former employer.

People's medicines were administered as prescribed. We looked at six people's medicine records and found gaps in one person's.

Staff were trained in safeguarding and knew how to keep people safe from avoidable harm.

People had individualised risk assessments that gave guidance to staff on keeping people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not always met.

Staff were knowledgeable about people's care needs and were trained to meet these needs.

People were supported to access other health and care services when required.

Is the service caring?

Good

The service was caring.

Staff were kind, patient and supportive of people.

They were respectful and friendly in their interactions with people.

People were supported to maintain relationships with their loved ones and had their privacy and dignity respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvement was required in the provision of meaningful activities and entertainment to the people who lived at the home.

People's health and care needs had been identified and plans put in place to meet these needs.

There was an effective system in place for handling complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The home did not have a registered manager in post because the provider had moved the Registered Manager to another location within the BUPA brand which had an impact on the quality of the service.

A new manager had been appointed and they were going through the process of registering with the CQC to become the registered manager.

The manager was approachable and supportive of staff and people who lived at the home. They had made some improvements to ensure that people's care was appropriately planned and delivered safely.

The provider had systems in place for monitoring the quality of the service provided.

Ridgeway Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 May 2016 and was unannounced. It was prompted by an increase in the number of reported safeguarding related incidents between the months of March and May 2016. The inspection was carried out by two inspectors from the Care Quality Commission (CQC).

Before the inspection, we reviewed information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. The local authority had recently carried out a monitoring visit of the home, so we gathered feedback from their visit.

During the inspection we spoke with six people who used the service and three of their relatives to get their feedback about the quality of the care provided to them. We also spoke with three members of the care staff, a member of the maintenance staff, an activities co-ordinator, the cook, a visiting professional, the deputy manager, the regional manager and the registered manager. We observed how care was delivered and reviewed the care records and risk assessments for six people who lived at the home. 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 looked at three people's medicines and medicines administration records, and six staff recruitment, training and supervision records. We also reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

Before this inspection we had received information that showed an increased number of safeguarding related incidents from this home. These incidents were in relation to allegations that people's needs were not being met safely. For example, concerns were raised around two people's nutrition and hydration needs not having been met when they stayed at the home for respite care. We found during our inspection that the provider was taking corrective action to address such issue. A new and more robust pre-admission assessment framework had been put into place to ensure that people's health and care needs had been identified before they moved into the home. The manager told us that the new pre-admission assessment processes would involve people and their relatives' input and would ensure staff had all the information about people's needs in order to meet them safely.

The provider had a recruitment policy in place which included checks with the Disclosure and Barring Service (DBS) to ensure that applicants were suitable to safely care for people. Prospective staff were also required to complete health questionnaires to ensure they were fit for the role they applied for. The provider also requested previous employment references. This supported the provider to determine whether applicants were suitable for the roles they were being considered for. We reviewed six staff records and found one to be hand written with no evidence that showed that they were provided by a genuine former employer. We raised this with the regional manager and they were going to work with the Human Resources (HR) team to address this.

People's medicines were administered as prescribed and stored in locked cabinets within the home's two medicine rooms. One person told us, "I have my medicine, they give them to me. I have usually got a drink and they put it on the table and I take it. If I have not got anything [to drink] they will get me some water. They are very helpful." There were protocols in place for people to receive medicines that had been prescribed on an 'as and when required' basis (PRN). We checked the stock of medicines held for six people against the medicine administration records (MAR) and found that one person's had gaps for the day of our inspection. We looked at the person's stock of medicines and it showed that they had been given medicines that day. We spoke to the person and they told us that they had received their medicines for that particular day. We raised this with the manager who contacted the member of staff responsible via telephone as they were off shift. The member of staff told the manager that they had supported this person with their medicines but had forgotten to sign the MAR to indicate this. With this confirmation, we found that this was an error in recording. The manager told us they would record and report this as a medicines error in line with the provider's incidents reporting procedures.

People had individualised risk assessments to safely manage the risks posed to them. These provided guidance for staff on keeping people safe and were reviewed and updated on a six monthly basis or earlier if required. Staff told us they kept up to date with the identified risks to people and how these were managed by reading people's risk assessments. People's risk assessments covered areas such as; safe moving and handling, falls, use of bedrails and safe access to the bathroom.

The provider had also carried out health and safety risk assessments to safely manage risks posed to the

people by the environment. These were in areas such as; slips trips and falls, stairs and landing, obstructed corridors and walkways, electrical safety, fire safety, lone working, clinical and general waste storage, hot water and hot surfaces, stress and hazardous substances. Risk assessments identified hazards that could cause harm, those who might be harmed and what was being done to keep people safe. The provider had also put emergency protocols in place to make sure people were kept safe in the event of a fire, adverse weather or any other unforeseen circumstances. People also had personal emergency evacuation plan (PEEP) which detailed how they could be supported if there was a requirement to evacuate the building in emergency situations. This was accompanied by the home's business continuity plan which detailed the steps the provider would take to ensure people's safety, in an event that stopped the home running the way it should.

People told us they felt safe living at the home. One person said, "I am safe." They showed us the front page of a newspaper they were reading which had 'good morning' written on it by the staff. They told us, "Things like this make me feel safe." Another person told us, "I am extremely safe. Outsiders can't come in and I am happy with security within the home." Relatives of people who lived at the home told us that their relatives were safe and had their needs met. One relative said, "I am happy that [Relative] lives here if [they] have to be anywhere. I honestly, am truthfully satisfied that [relative] is here." A visiting professional we spoke with also said, "This is a lovely place, especially when compared with some I go to."

The provider had an up to date safeguarding policy in place which the staff had read and signed to say they were going to adhere to it. Staff had been trained on safeguarding people, and they demonstrated a clear understanding of their responsibilities in this. They were able to tell us the types of risks that could affect the people they supported, the measures that were in place to reduce the risks and the actions they would take if people were unsafe. One member of staff said, "My safeguarding training was done. If I felt people were [not safe] I would report to the manager, the deputy manager or to my team leader. I could also go to the next step up to the regional manager." Another member of staff told us, "I will happily pick up the phone to the safeguarding team for any questions I may have." The provider also had an up to date whistleblowing policy in place. This gave staff a way in which they could report concerns within their workplace without fear of consequences of doing so. Staff told us they had read and understood this policy and would use it if there was a need to do so. A review of staff records confirmed this policy was made available to them.

People and their relatives told us that the home was adequately staffed to safely meet people's needs. One person said, "There is enough staff, yes. They have enough time to talk with me." Another person told us, "There is enough staff although sometimes when they are busy you have to wait your turn." A relative we spoke with said, "I think there is enough staff but they don't seem to stay long. They seem to have a big turnover. It's what it seems to me but it may not be." A review of the staff roster confirmed that the number of staff on duty corresponded to the number of staff the manager told us were needed to meet people's care needs. We observed that there was enough staff and people were being supported promptly.

Requires Improvement

Is the service effective?

Our findings

Before our inspection, we received concerning information that some people were not being supported to eat and drink enough to maintain their health and wellbeing. We found that the provider was taking steps to address this issue. For example, they had put into place food and fluids charts to monitor how much people ate and drank so that action could be taken in a timely manner if there were concerns. We reviewed the food and fluids charts of six people and found that one person's chart was not fully completed and therefore we were unable to determine if they were eating and drinking enough fluids. The food charts contained a section where a senior member of staff could audit them on a daily basis to make sure they were completed correctly but this was not done. The fluids charts did not have this section. We raised our concerns with the manager and the regional manager and they told us they were going to take action to address these.

People and their relatives felt that the care provided was effective because staff were trained, skilled, experienced and understood their roles. One person said, "The staff are good, they know what they are doing." A relative told us, "They do understand what support [Relative] needs." They further stated, "I have never needed to ask anything they have not been able to answer." Another relative we spoke with told us that they were very impressed with the home and their relative felt the home was like a hotel as they liked living there so much.

People told us they had enough to eat and drink. They were provided with a choice of food, snacks and drinks. One person told us, "The food is fine. The portions are just about big enough. I always have a drink available and snacks are built into the day." Another person said, "I am very fussy about my food. They usually find something I want to eat. I can't criticise them. The food is well prepared and is enough for me but I am not a big eater. We get 3 meals a day. The main meal is usually lunchtime and evening meal is usually sandwiches. The tables are well laid out and are nice and tidy. The presentation is very good and the atmosphere is pleasant." One person told us they were able to have their breakfast of choice when they requested it. They said, "I wanted kippers for breakfast and they got them in for me." A relative we spoke with told us, "Food wise it is very good. I don't think I can fault it. They do sometimes forget to fetch [relative's] drink."

We spoke with one of the cooks and they told us, "BUPA produce the principal menu and a book of recipes but this is used as guidelines and the cook has adjusted it if people didn't like it. Team leaders let us know of any special diets and they write it on the menu sheet. Some people have fortified diet, some soft diet. It is written on the menu sheets. One lady likes her hot food at night and she gets it. One gentleman likes kippers for breakfast so every 2 days he gets kippers." We observed people having lunch and found that tables were set very nicely with linen napkins and glasses. People were offered a glass of wine, water or juice with their meals. Meals looked very appetising and served directly from the hot trolley. People had a choice of Cumberland sausage or lamb mince with mashed potato and an assortment of fresh vegetables including carrots, broccoli and cabbage. Where required, people were assisted to eat with dignity and patience. Staff spoke to them as they ate and encouraged them to eat as much as they wanted.

The principles of the Mental Capacity Act 2005 (MCA) were not fully met. 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). Staff had received training on MCA and DoLS. Where it was required to deprive people of their liberty under the Mental Capacity Act to safely care for them, the provider had applied to the local supervisory body to have this granted. We found however, that some people had been assessed as lacking the mental capacity to make certain decisions but the provider did not carry out best interest decisions meetings in line with the MCA 2005. For example, one person's care records showed that they were assessed to lack the mental capacity to make decisions around their care planning but no best interest decision meeting was held to decide what was in their best interest and to make decisions to that effect. We fed this back to the manager and the regional manager and they told us they would take action to address this.

People, their relatives and members of staff told us that people's consent was sought by staff before the provided any care or support. One person said, "They always ask me before they do anything. They are always very polite." A relative we spoke with told us, "They always ask permission before doing anything." A male member of staff told us, "I always ask [before supporting them] and never ever presume they will let you support them with personal care. If they are not ready I will go back. I help with bath/showers mainly for the gentlemen, I support a few ladies but only with their consent. If they refuse I cannot do it." We observed staffs' interactions with people and saw they asked people's permission before they supported them. Some people had signed consent forms in their care records giving the staff consent to support them as detailed in their care plans.

People's healthcare records showed that they were actively supported to maintain their health and well-being. They had access to healthcare services when required and their known health conditions were recorded in their care plans. The service routinely monitored people's healthcare needs and supported them to access the right health care services when changes occurred. These were recorded with outcomes in each person's health plan.

Staff told us they had received a full induction at the start of their employment with the home. A member of staff we spoke with told us, "I received an induction. I spent the first week of my induction totally shadowing other staff. I had an induction course [which took] four days. We did moving and handling and had tests at the end. If they think you are not ready, they bring you back to the home or give you a longer probation period. It was one of the most vigorous inductions I have ever been on." The home's induction programme gave new staff the opportunity to read through people's care plans, become familiar with the home's facilities and work alongside experienced members of staff on shift till they became confident to take up their full job roles.

Staff were trained in areas that were relevant to the needs of the people that lived at the home. One member of staff told us, "Training topics we covered were basically dementia, safeguarding, health and safety, moving and handling." Another member of staff said, "The dementia care [training] really helps you understand people's needs." A member of the management team told us, "We have training coordinators who manage the training matrix. They alert us when training is due and send the dates when they are coming to do it. Training is face to face with just a couple done online." We reviewed the home's training records which confirmed that staff had received training in safeguarding people, medicines administration,

mental capacity act, food safety, dementia awareness, moving and handling and positive behaviour support. Some members of staff had been able to gain nationally recognised qualifications in health and social care, including National Vocational Qualifications (NVQ) and Qualifications and Credit Frameworks (QCF). One member of staff told us, "BUPA is supporting me to get NVQ3, I had to apply for it. It is a 12 months course."

Staff told us that they were supported in carrying out their job roles by way of regular supervision meetings with the home's management team and annual appraisals of their performance. A member of staff said, "I have supervision with [Name] every 2 months." Another member of staff told us, "I have not had any supervision yet. [Manager] has only just started and she has a lot on her plate." One other member of staff said, "Supervision happens in different forms. There is 1:1 supervision and group supervision. The last one was a group supervision about a safeguarding incident when we discussed skin care and the needs of people we support on a short-term basis (respite)." We reviewed the home's supervision and appraisal records which confirmed that appraisals were last carried out in January 2016, with upcoming staff supervisions already scheduled.

Good

Is the service caring?

Our findings

People we spoke with told us staff were caring. One person said, "I am happy living here. It is staff's attitude that makes me happy. They are happy, friendly and nice." Another person told us, "I am extremely happy. The staff are excellent. I can't speak highly enough of them." One other person said, "The staff are nice." The relatives of the people we spoke with also told us the staff were kind and caring. One relative told us, "I can't really find an awful lot to fault. They are ever so good. They put themselves out I don't think I could find any better." Another relative told us, "I would not do their job. I have never seen anything that has concerned me. I have never seen staff talk to people inappropriately. They are always very nice and so patient." A visiting professional we spoke with added, "I have never seen anything that has concerned me. Staff talk to people nicely."

People's care records contained information about their preferences and things that were important to them. There was a specific part of people's care records called 'My Story'. This contained details of where people were born, where they lived most of their childhood, where they lived as adults, the schools they attended, the friends they had, the holidays they've been on, what they did for work, names of any pets they had and their family tree. Staff told us this made them know people's history and backgrounds so that they could support them in a way met their preferences and lifestyle choices.

The atmosphere within the home was very relaxed. People appeared comfortable and at ease in the company of staff. We observed staff's interactions with people and found them to be in a caring and positive manner. Staff were knowledgeable about people's care needs and were able to tell us the ways in which they ensured people were well cared for. One member of staff said, "I love my job", when they spoke to us about people they supported. We observed that staff spoke with people appropriately and called them by their preferred names.

People were supported to express their views and be actively involved in making decision about their care. People and their relatives had been provided with a service user guide called 'Welcome to Ridgeway Lodge'. This detailed information about the home, who key staff were, information about meals, activities, health care, and who people could contact if they had any concerns. Some people's relatives or social workers acted as their advocates to ensure that they understood the information given to them and that they received the care they needed. Some people had support from independent advocacy services if they needed it. Information about advocacy services was displayed in the home's entrance hall.

People's bedrooms were spacious and decorated to their own taste. Each person's room was personalised with pictures and items that were important to them. People were encouraged and supported to maintain relationships with their families. Their relatives were able to visit them when they wanted. One person told us, "I have my own phone. I was able to keep my old number so that my family could call me. My family can come to visit me whenever they like. They just turn up." A relative told us, "They have no problem with me bringing our dog in 3-4 times a week to see [relative]. I can come at any time, there is no visiting time."

People's privacy and dignity were respected by the staff. One person told us, "They knock on my door before

coming in and they always ask me before they do anything." A relative told us, "They always knock on the door, even when it is open and they are just bringing a cup of tea." A member of staff told us, "I always knock on their door before I walk in." We observed that people were given opportunities to spend time in their bedroom when they wanted. Staff understood the need to keep people's information private. Information about people was kept securely to ensure that sensitive information was confidential.

Requires Improvement

Is the service responsive?

Our findings

Prior to the inspection, we had received concerning information that related to poor assessment and identification of people's care needs before they moved into the home. However, we noted that the provider had taken steps to address this. For example, they had changed the pre-admission assessment documents to ensure that all the information relating to people's care needs were captured. This was to help them develop more robust care plans that would give staff guidance on how they would fully meet people's needs. We compared the new pre-admission assessment framework to the old one and found it to be more robust.

We checked the pre-admission assessment form for a person who moved to the home on respite care on the day of our inspection and this showed that they and their close relatives had been involved in the assessment process. The provider had also put in place 'discharge summary' paperwork for people who stayed at the home for respite. This showed the activities and outings people had taken part in, interactions with health and care services, people's skin condition at the time of discharge, any food or fluids intake issues, people's mobility, sleep patterns and any other concerns that might have arisen during their stay at the home. This made it easier to record issues they needed to communicate with other professionals involved in the person's care. A group supervision meeting was also held by the provider to address the issue of the poor assessment and identification of people's care needs. A review of this meeting's minutes showed that discussions were held around keeping robust records about people's skin integrity and pressure care. This included actions that staff were to take on admitting new people into the home in order to reduce the risk of further concerns being raised in the future.

People were able to take part activities and hobbies that were of interest to them. Some people were supported in this by their relatives. One person told us, "My daughter's come twice a week and takes me out." People contributed to the planning of activities during 'residents committee' meetings. Most people told us that the level of activities or entertainment provided by the service could be increased. One person said, "I do activities. Reading the paper is an activity. There is entertainment but not very much." Another person told us, "There has been some entertainment but not on a regular basis, only occasionally." We spoke with the manager about this and they told us part of their plans for the future was to increase the level of activities and entertainment for people. They said, "It is difficult to tailor group activities to meet everyone's individual needs. It is breaking the culture and mind-set that activities happen only between 10am and 5pm that is needed." We saw that people had 'activities and interactions logs'. These monitored the activities people took part in. We reviewed these for two people and found that the activities they mainly took part in were 'keeping fit with [Name], film club, sherry making, singing and dancing, Tuesday's pre-dinner drinks/happy hour, games club and cake making.

People and their relatives told us people were cared for in a way that was personalised to them and that they were involved in planning their care. One person said, "They did talk with me about what I needed before I came in." A relative told us, "They came out and talked about what care they could offer." Another relative said, "I had lots of forms to fill in when [Relative] came here. What [they] likes/doesn't like, what [they] can and can't do and stuff. We went through [their] medication as well."

Each person that lived at the home had a personalised care plan that followed a standard template used within the home. People's care plans held information about their history, their preferences, interests and hobbies. They also detailed guidance for staff on how people wanted to be care for. We saw that people's care plans were reviewed on a monthly basis and they had annual care reviews that involved their relatives, and health and care professionals involved in their care.

The provider had a system for receiving and handling complaints. People and their relatives told us they knew who to raise concerns with if they had any. One person said, "If I had a complaint I would talk to one of the staff. They listen." We found that the provider had complaints leaflets and 'customer feedback' suggestion box in the home's entrance hall. The people we spoke with told us they were happy and did not have any complaints to make with one person saying, "At the moment there is nothing I want changed."

The provider had taken steps to address the issues that prompted this inspection. We found for example, the local safeguarding team had requested that the manager investigated an allegation that a member of staff had physically abused a person who used the service by 'tapping' them on their right forearm. This was investigated and the member of staff was issued with a formal warning.

Requires Improvement

Is the service well-led?

Our findings

We carried out this inspection in response to information that showed an increase in the number of safeguarding related incidents where people's needs had not been met safely. Some of these concerns had been investigation by the local safeguarding team, and others assessed as not proportionate for safeguarding investigations. Where this was the case, the provider was asked by the safeguarding team to undertake enquiries and steps to address the issue. There were cases that were investigated by the local safeguarding team and the allegations were substantiated. The provider and the manager were taking steps, for example, the implementation of the new pre-admission assessment framework for new people, to address the concerns. The had also reported concerns in an open and transparent way.

The home did not have a registered manager at the time of our inspection because they had moved to another location within the BUPA brand. As a result of this planned move the home was without a registered manager since December 2015 and in breach of the condition of registration that the location must have a Registered Manager. This transition had a negative impact on the quality of the service because the level of care we saw during our inspection of February 2015 was not sustained.

A new manager had been appointed and they were going through the application process to become the registered manager of the home. The new manager was supported by a deputy manager, team leaders, senior members of staff, the care and domestic staff team and the provider's area manager.

People, their relatives, staff and care professionals we spoke with told us the new manager was visible, approachable and supportive. One person said, "[Manager] is nice. [They] would talk with me more if I let [them]." A relative told us, "There is a different manager now. She is very nice. She has come to talk to me." Another relative said, "[Manager] is lovely. She talks to me. She spends as much time with as many people as she can." A care professional we spoke with told us the manager was very open and honest and was actively working on improving the service. A member of staff added, "I feel really supported. [Manager] and [Area Manager] instantly gave me opportunities when they knew I wanted to [develop within my role]. [Manager] has a nurse background and I am learning more clinically."

The manager was clearly knowledgeable about their role and responsibilities. We observed their interactions with people, their relatives and staff and found these to be positive and professional. They were aware of the day to day operation of the home and people appeared to be at ease in their company. They told us they had an 'open door' policy so that people and visitors could see them when they liked.

People were engaged and involved in the development of the service by way of monthly 'service users' meetings. We reviewed the minutes of the last meeting held on 20 April 2016. The topics of conversation included; a new call bell system that was being installed, new staff members, upcoming activities such as the Queen's birthday celebrations, and a new 'residents committee' that was being set up. The 'residents committee was another way that people were involved in the development of the home. This was an initiative set up by the manager to engage with people more and give them more opportunities to provide feedback. The committee was made up of a group of people who were chosen to be representatives of the

people who lived at the home. The plan was for them to meet regularly so that people could have a direct say in the running of the home. The initial meeting took place on 17 May 2016 and people told us that it was a positive meeting. We saw that people used this meeting to nominate a member of staff as their 'everyday hero. This member of staff was then presented with a voucher as a way for saying thank you for their work.

Staff were also involved in the development of the home. Daily 'ten by ten' meetings were held where staff and the manager had discussions about issues that affected the home. For example, maintenance issues, staffing levels and people's care needs. Regular staff meetings were also held. A member of the management team told us, "Staff meetings are held quarterly. Staff talk about concerns and further training coming up. We ask staff how they are feeling during these meetings, and if there is anything they would like to see happen or changed. If staff make suggestions we look at them and do an action plan. If it benefits the home, residents or staff we see if it makes a difference. Staff input is vital to the home." We reviewed the minutes of the staff meeting held on 19 May 2016 and found that the areas discussed involved residents committee feedback, infection control and the provider's social media and uniform policies.

Annual satisfaction surveys were also completed. These gave people and their relatives the opportunity to formally give the provider their feedback of their experiences of the service. A relative we spoke with told us, "I have had a satisfaction form." We found that the feedback received from the last survey was mainly positive with people and their relatives saying they were satisfied with the level of service.

The provider had a quality monitoring process in place to drive continuous improvements in the service delivered to people. The home's management team carried out audits on a weekly and monthly basis. These audits for example included checks of people's medicines, care plans and staff training. The results of the audits and actions plans fed into the home's 'quality matrix'. The quality matrix was developed by the provider to measure and monitor the quality of the service. This was designed around the service provided to people and measured care in four themes. The first was 'quality of care', the second, 'people's quality of life', the third, quality of leadership and management', and the forth, 'quality of the environment'. The area manager told us that this system ensured accountability within the organisation and helped in the reduction of incidents including falls, spread of infection and the development of pressure ulcers. The manager said, when they commented about the home, "The home offers really good care. I have a really good team and it feels really homely. I like to run places that I would be happy for my Mum to be in."