

Windsar Care Limited

Salt Hill Care Centre

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

Salt Hill Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. We regulate both the premises and the care provided, and both were looked at during this inspection.

Salt Hill Care Centre can accommodate up to 53 people (including couples) and provides nursing care, personal care and respite care to older and younger adults living with dementia, physical disabilities, learning disabilities and mental disorders. At the time of our visit there were 49 people using the service.

The provider is required to have a registered manager as part of their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection, there was a registered manager in post.

When we completed our previous inspection on 4 and 5 May 2017, we found concerns relating to end of life care. At the time this area was included under the key question of 'Caring'. We reviewed and refined our assessment framework and published the new assessment framework in October 2017. Under the new framework this area is included under the key question of 'Responsive'. Therefore, for this inspection, we have inspected this key question and also the previous key question of 'Caring' to make sure all areas are inspected to validate the ratings.

At our previous inspection, the provider was rated 'Requires improvement' in all key questions of 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well-led'. We found a number of breaches in the Health and Social Care Act 2008 (Regulations) 2014. We asked the provider to send us an action plan to show what improvements would be made, by 23 July 2017. The provider submitted the action plan by the specified date.

We found the service had made the required improvements and are now rated 'Good' in all key questions.

People and relatives gave positive comments about the caring nature of staff. Comments included, "(Staff) very friendly, tolerant, forgiving and always around to help", "They (staff) are always quite cheerful."

People told us staff made sure those close to them felt like they mattered. Staff had a good understanding of people's care and support needs. Staff ensured people's privacy and dignity was respected and they were supported to be independent. Information about people was kept secure.

People said they felt safe from abuse. Comments included, "I feel quite safe" and "It's as safe as houses. I would speak to (name of staff) if I felt unsafe."

People were protected from harassment, discrimination and breaches of dignity and respect. Staff were aware of their responsibilities to safeguard people from abuse. Safe recruitment practices were in place and there were sufficient staff to care for people. Risks to people's safety were assessed and medicines were administered safely.

People were cared for by staff who were appropriately inducted and trained. People's nutritional needs were met. They were supported to live healthier lives and had access to healthcare services.

We have made a recommendation in relation to the provision of snacks. This was because people and relatives told us there was not a wide variety of snacks on offer. This was confirmed by our observations.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service showed the service acted in accordance with the Mental Capacity Act (2005).

End of life wishes and preferences were captured with people and their relative's involvement. The service was responsive to peoples' care needs and social well-being. All complaints received were responded to in line with the service's complaints policy and procedure. Reviews of care were not carried out consistently and documented.

We have made a recommendation in relation to reviews of care.

People, relatives and staff were positive about the service and how it was managed. There were effective quality assurance systems in place to monitor and assess the quality of the service delivered. The service sought feedback from people and their relatives' however, they acknowledged further work was still required in this area.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People said they felt safe and staff knew how to keep them safe.

People's personal safety had been assessed and plans were in place to minimise identified risks.

There were sufficient numbers of suitable staff, robust recruitment were in place and medicines were administered safely.

Is the service effective?

Good ●

The service was effective.

There were issues in relation to snacks, we have made a recommendation about this.

People were cared for by staff who were appropriately inducted and trained.

The service acted in accordance with the Mental Capacity Act (2005).

People were supported to live healthier lives with access to healthcare services.

Is the service caring?

Good ●

The service was caring.

People and relatives made positive comments about the caring nature of staff.

People told us staff made sure those close to them felt like they mattered.

Staff ensured people's privacy and dignity was respected and they were supported to be independent.

Is the service responsive?

Good ●

The service was responsive.

Reviews of care were not carried out consistently and documented. We have made a recommendation about this.

End of life wishes and preferences were captured with people and their relative's involvement.

The service was responsive to peoples' care needs and social well-being.

All complaints received were responded to in line with the service's complaints policy and procedure.

Is the service well-led?

The service was well-led.

People, relatives and staff were positive about the service and how it was managed.

There were effective quality assurance systems in place to monitor and assess the quality of the service delivered.

The service sought feedback from people and their relatives but acknowledged further work was still required.

Good ●

Salt Hill Care Centre

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 checked 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 was carried out on 31 July and 1 August 2018. It was unannounced which meant the service was not aware we would be visiting. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection the provider completed a Provider Information Return (PIR). A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The information in this form enables us to ensure we address potential areas of concern and any good practice. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

We used the Short Observational Framework for Inspection (SOFI) to observe the care and support provided to other people in the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six people; two relatives; two registered nurses; two care workers; an activity co-ordinator; the deputy manager and registered manager. We looked at seven care records, five staff records and records relating to management of the service and observed care practice and the environment.

Is the service safe?

Our findings

At our previous visit on 4 and 5 May 2017, we found a number of concerns. The service's local safeguarding abuse policy was not up to date; staffing levels were not continuously reviewed and adapted to respond to people's changing needs and circumstances. There were no remedial actions to ensure people's and others' safety from the risks of Legionella. Recent water sample results to check for the absence of Legionella within Salt Hill Care Centre's water supply were not acted upon. Appropriate interventions were not planned to mitigate the risk of Legionella. The service's fire risk assessment showed 25 'significant findings' or 'actions' that were required. There was no evidence that routine checks required by the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) for the passenger lifts and hoists used to move people, were regularly completed. This meant people were placed at risk of harm from the premises or equipment.

Staff did not keep a running count of medicines which were in bottles or packets. Topical medicines charts or maps were not always in use to show what medicines (in the form of creams, lotions or ointments) were applied to the body. Staff members did not always perform hand hygiene between giving each person their medicines. There was no signage or documents which indicated the safe temperature ranges for the medicines. Where people were prescribed anticoagulant medicines (medicines used to prevent blood clots), care plans did not detail what to do if any type of trauma or bleeding happened. Staff had not consulted the GP or the pharmacist to have the frequency of 'as required' medicines verified or medicine administration records (MAR) changed. These practices meant people were at risk of harm from incorrect administration of medicines.

Storage for sharps, such as injection needles, were not available with medicines trolleys or situated anywhere else for their safe disposal. This meant staff were not safe as there was a risk they could sustain a 'needle stick' injury.

During this visit, we viewed the service's safeguarding policy and found it was up to date. Dependency assessments were undertaken to assess people's level of needs and regularly reviewed to ensure there were sufficient staff. People told us there were sufficient staff. Comments included, "All regular staff on this floor. I have a key worker" and "Fairly regular staff depending on shifts."

Regular water sampling tests showed there was an absence of Legionella in the home and documents showed a variety of checks were carried out to ensure people's and others' safety from the risk of Legionella. For instance, regular flushing of unused outlets.

Health and safety risk assessments of the premises showed all findings and recommendations were acted upon. For instance, a view of the most recent fire risk assessment showed all 25 significant findings previously noted had now been addressed. This was further confirmed by a letter dated 27 September 2017 from an authorised fire inspecting officer, who stated the service now had reasonable fire safety measures in place.

We looked at the service's medicines policy and procedures and carried out observations of medicines

rounds. We found appropriate remedial actions had been taken to address all the concerns we found at our previous visit. For instance, documents now showed the running counts of medicines contained in bottles or packets; staff ensured they followed recommended best practice when handling medicines. There were records and clear signage of safe temperature ranges for medicines and anticoagulant care plans were in place which provided staff with all the relevant details and actions to be taken if any injuries or trauma happened. A registered nurse informed us that all medicines were electronically prescribed by the GP which meant all amendments or changes to medicines (including 'as and when required' medicines) could only be made by the GP. A view of MAR charts confirmed this. We observed sharp boxes were easily accessible and kept in medicines trolleys. We viewed the most recent 'medication system audit' carried out by a pharmacist on 12 January 2018. This showed all recommended actions identified had been addressed by the service. This meant where the service was responsible for medicines, staff met good practice standards described in relevant national guidance, including protocols which related to non-prescribed medicines.

People said they felt safe from abuse. Comments included, "No one can harm me. There are some aggressive patients and the odd wanderer, staff are able to keep people calm", "Yes (felt safe from abuse). There's never any aggression", "Yes, it's alright. I never had any concerns", "I feel quite safe" and "It's as safe as houses. I would speak to (name of staff) if I felt unsafe."

People were protected from harassment, discrimination and breaches of dignity and respect. A registered nurse commented, "I inform staff of people's preferences and provide hands on training to ensure staff know how to treat people with dignity and respect."

Staff were aware of their individual responsibilities to prevent, identify and report abuse. Staff had received safeguarding training and where safeguarding incidents happened, the service took appropriate action and reported them to the relevant agencies such as the local authority and the Care Quality Commission (CQC).

People felt risks to their health and welfare were managed positively. Where risks to people's health were identified, care records showed the service made sure people or those who represented them were involved in decision making relating to those risks. For instance, a person commented, "I had a stroke it effected my left side and I did consent to bed rails. It was discussed with me and they (the service) have taken my views into consideration."

Care records contained risk assessments that covered the health, safety and welfare of people who used the service. We saw control measures were put in place to make sure there was a balance between people's needs and safety risks with their rights and preferences. These were regularly reviewed.

Recruitment systems were robust and made sure the right staff were recruited to support people to stay safe.

People felt happy with the support received regarding medicines and had no concerns. Comments included, "I have medication every day and I am quite happy", "They (staff) bring my medication. I am okay with that", "I take medication. I'm a diabetic and take both tablets and injections. They (staff) take care of all of that." This was confirmed by their relative who commented, "Yes, she (family member) is diabetic and has injections twice a day. We have no concerns."

People were positive about the cleanliness of the premises and stated they observed staff carrying out good cleanliness and hygiene practice. Comments included, "It's (the premises) cleaned routinely. (Staff) always wear aprons when serving food and handling people", "It's cleaned every day (their room & shower) and they (staff) wear gloves and aprons" and "It's very clean. I have seen them (staff) wearing gloves and aprons."

People were protected by the prevention and control of infection. Staff had access to policies and procedures on infection control that met current and relevant national guidance, and were kept up to date.

Is the service effective?

Our findings

At our previous visit on 4 and 5 May 2017, we found staff did not receive appropriate induction and training. The service was not compliant with the requirements for consent, MCA and DoLS and the associated Codes of Practice.

During this visit, we found people were cared for by staff who were appropriately inducted and trained. Staff spoke positively about their induction and training experience. Training records showed staff had completed all the standards of the Care Certificate. This is training all care workers new to health and social care are required to complete. In addition to this, skills and competency assessments were undertaken to make sure new care workers were aware of their roles and responsibilities. Assessments documented observations of how they applied their learning to practical care tasks. Supervision records documented how staff were supported to develop and review their practice or behaviours. This meant people received care from staff who had the skills, knowledge and experience to deliver effective care and support.

Mental capacity assessments were fully completed and contained relevant details, including involvement from people's representatives and health care professionals. This showed decision making considered the least restrictive options. People's ability to consent to care was considered and discussed. The service had made appropriate Deprivation of Liberty Safeguards (DoLS) applications to the (supervisory bodies) to ensure they lawfully deprived people of their freedom. We found conditions on authorisations to deprive people of their liberty were met and staff nursing stations had a list of people who were subject to DoLS, the date they had been authorised and their expiry dates.

Records showed information was sought to find out if relatives or representatives of people, who lacked the capacity to make specific decisions relating to their health; welfare and finance, had an existing Enduring Power of Attorney (EPoA) or Lasting Power of Attorney (LPoA). For instance, correspondence from the Office of the Public Guardian confirmed whether people were on their registry. Staff nursing stations had a list which showed whether or not people had EPoAs or LPoAs in place. We saw the service carried out 'best interest decision' meetings with relatives or representatives who did not have legal powers to act on people's behalf.

Where people were administered their medicines covertly (covert medicines are medicines that are usually disguised in foods or drinks, which enable people to take them without being aware), the service acted in accordance with the Mental Capacity Act 2005.

People gave mixed views about their meals. Comments included, "This is where the place lets itself down. Powdered mash and everything cooked from frozen. There are biscuits served with tea but we would benefit from more fresh fruit. I can go out but others are not able", "Food is terrible. I don't like it at all. I just drink tap water (we observed a jug of juice in their room). There are biscuits available", "I get plenty to drink, the food is good", "It's a set menu and they (staff) do help me with my food. There's just biscuits for snacks. They bring tea and biscuits and there is a jug (of juice)", "Plenty to drink and the food is alright." Relatives comments included, "Food is reasonable, she (family member) does like her food and can be "so so"

sometimes. There's not an option to eat anytime, teas, biscuits and meals are offered at specific times throughout the day" and "We're not always sure that she (family member) gets enough to drink when we're not here. The food is good and they take care of me (relative) as well."

People were supported to eat and drink and to maintain a balanced diet. We used SOFI to observe three people who were supported to eat at lunch time. The meals on offer were nutritious, appetising and served at the right temperature. People were relaxed and ate their meals at their own pace. Most of the staff engaged positively with people and gave assistance to those who required further support to eat their meals. Staff were attentive and used positive words to encourage people to eat their meals. A staff member commented, "We encourage residents to have the right amount of protein, carbohydrate and fluids. We offer additional food supplements for people who are losing weight." Care records identified people who were not eating and drinking in line with their assessed needs and how this should be managed by staff.

Although people had nutritional balanced meals and sufficient drinks for breakfast, lunch and dinner, we observed there was not a wide variety of snacks on offer. Although people who were more independent had the opportunity to make their own snacks and drinks, the option of choice of snack was not available to everyone.

"We recommend the service considers steps it could take to improve the provision of snacks for everybody receiving care.

People said they were supported to maintain good health and staff helped them to understand any information and explanation regarding their health. Comments included, "They (staff) will keep me informed and help me when needed. They come in at night to help me go to the toilet" and "They (staff) will help with my compression socks, help me shower and cream my legs. They explain anything I'm not sure of."

People were supported to live healthier lives and had access to healthcare services and receive on-going healthcare support. Where people had specific medical conditions, plans of care were put in place to show how their health needs would be met. Care records documented visit notes from health professionals such as the GP, dentists, dietitians and opticians and how staff worked in partnership with them. 'Resident transfer forms' were in place in the event people needed to be moved to other services or were admitted to hospital. These made sure health services were aware of people's communication, health needs and preferences.

People had access to outside space that had been assessed for risks. Adaptations to the premises were laid out in a way that were accessible and helped to promote people's independence.

Is the service caring?

Our findings

At our previous visit on 4 and 5 May 2017, we found people were not always treated with dignity and sometimes received care that was impersonal. During this visit, we observed care practices on the various units. Staff treated people with dignity and the care delivered was person-centred.

People and their relatives gave positive comments about the caring nature of staff. Comments included, "(Staff) are very friendly, tolerant, forgiving and always around to help", "They (staff) are always quite cheerful", "They (staff) are kind, caring, happy people and they will come and chat if they have time", "I sometimes get cross with them when they rush me but they are very patient though", "They (staff) are kind, compassionate and understanding with the residents" and "The job they (staff) have means they sometimes have to be firm with people. Overall, they are brilliant at what they do and are happy and patient."

This was supported by one of the many 'thank you' cards people had sent to the service. For example, a relative wrote, "I would like to take the opportunity to thank you all for your care and kindness whilst (name of person) was staying with you at Salt Hill. There was always a warm welcome and a cup of tea when we arrived, nothing was too much trouble for you to care for (name of person). He was well loved by everybody. I am sure he lasted longer because of the care you gave him."

Staff interacted with people in a friendly and caring manner. They referred to people by their preferred names and spoke to them all respectfully. One member of staff sat with a person and gave them a hand massage whilst talking to them. Another person was shouting and staff were able to calm them down quickly and effectively.

People said staff made sure those close to them felt like they mattered and relatives confirmed there were no restrictions on how many times they could visit. Comments included, "Usually they (staff) are very nice to my visitors" and "They (staff) are very respectful and welcoming to visitors." This was confirmed by relatives whose comments included, "No restrictions. My wife and son visit every weekend and are made to feel welcome" and "We are always made very welcome."

People received care and support from staff who had a good understanding of their care needs, personal histories and family backgrounds. This was confirmed by our discussions with staff who spoke confidently about the people they provided care and support to.

People said their privacy and dignity was protected when staff carried out intimate care. Comments included, "I don't need personal care but where a resident has had an accident, the staff are quite discreet and minimise humiliation", "They (staff) knock before coming in and call out if I'm in the bathroom", "Yes, they (staff) do close the doors when I'm being showered" and a relative commented, "She (family member) has never been happy having personal care but they treat her very well."

Staff explained how they made sure people's dignity was protected. A staff member commented, "We cover people's private parts, talk to them and check to see if they are happy for us to carry out intimate care."

Training records confirmed staff had attended training to ensure people were treated with respect and dignity at all times.

Most of the people we spoke with said they were able to be as independent as they wanted to be. Where this was not possible, care records clearly showed what tasks people were not able to perform and how staff should support them.

Is the service responsive?

Our findings

At our last visit on 4 and 5 May 2017 we found people's choices about end of life care were not reviewed and did not involve appropriate others, to determine if changes were needed.

We have inspected this key question to follow up the concerns found during our previous inspection on 4 and 5 May 2017. End of life care was under the key question of 'Caring' in the previous assessment framework, but was moved to this key question when the framework was reviewed and refined.

We also found initial assessments did not have sufficient appropriate information to capture people's care needs. People with diabetes did not have specific care plans tailored to their needs. Where people were at risk of developing pressure ulcers, appropriate measures were not taken to mitigate the risk. People were at risk of becoming socially isolated and complaints were not handled appropriately.

During this visit, we found end of life care plans and advanced care plans documented the involvement of people's relatives, representatives and relevant health care professionals. Where people or relatives chose not to be involved in discussions concerning end of life wishes and preferences, this was clearly recorded. Reviews were regular and the appropriate care plans were updated and changed when there were changes in people's circumstances.

Initial assessments viewed were comprehensive, captured people's immediate and longer-term needs and were based upon national recognised evidence. This included, amongst others, their health, personal care, emotional, social, cultural, religious and spiritual needs. This meant the service delivered care that was responsive to people's needs.

People with diabetes had diabetes care plans in place which covered all aspects of care related to their diabetes, such as regular blood tests and foot care. A person commented, "I have regular checks for my diabetes."

Where people were at risk of developing pressure ulcers, care records documented what actions staff should take to mitigate the risks of people developing pressure ulcers. Staff team meeting notes documented staff were instructed to make sure equipment used to prevent pressure ulcers were used correctly and checked daily. Nationally recognised guidance and best practice on the prevention and care for people who had pressure ulcers were displayed in all staff units.

The service was responsive to people's social well-being. The registered manager told us they now had three activity co-ordinators in post whose roles were to focus on people's social needs. People spoke positively about the activities they participated in and enjoyed. Some people told us their preference was not to get involved and staff respected their choice. We saw photographs of recent social events, such as a summer barbeque, which showed people and staff having an enjoyable time. An observation of an activity session showed people playing with jigsaws and participating in painting. The activity co-ordinator was enthusiastic in their approach and interaction with people and spoke passionately to us about their plans to get more

people involved.

There were effective systems for identifying, receiving, handling and responding to complaints. We observed the complaints policy and procedure was visibly displayed and in formats other than English. It documented the names and contact details of the company directors, if people wanted to escalate their concern to higher within the organisation. We viewed the complaints log and found information documented was detailed; contained records of investigations and their outcomes and whether complaints were resolved to people's satisfaction. All complaints were responded to in line with the service's complaints policy and procedure. People and relatives told us they knew how to raise complaints and when this had happened, the service acted appropriately and to their satisfaction.

Reviews of care were documented and captured people's views on the care and support delivered. However, we found these were not undertaken on a consistent basis even though care plans and risk assessments were regularly reviewed and kept up to date. This was supported by a person who commented, "I can't recall an update."

We recommend the service seek current guidance and best practice on carrying out and documenting reviews of care.

People and relatives described the responsive nature of staff, "I haven't needed any pain killers, where there is a need amongst residents' the staff are quick to respond", " I have no problem with them (staff), they are very prompt when you need something" and "They (staff) would notice if she (family member) was unwell. They reacted fairly quickly when she had her fall."

The service acted in accordance with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care records clearly identified people's communication abilities and how staff should communicate with them.

Is the service well-led?

Our findings

At our previous visit on 4 and 5 May 2017 we found quality assurance systems did not operate effectively to ensure the welfare and safety of people who used the service. Information requested by the CQC was not submitted by the required deadline; there was unsatisfactory management support; records relating to the care and the management of the service were not fit for purpose; people and their relatives were not given the opportunity to provide feedback about the service delivered.

During this visit, we found improvements in management of medicines; health and safety checks; staff induction and training; complaints management; audits with analysis undertaken to identify any trends and mental capacity assessments documented the involvement of relatives. There was an emphasis on staff ensuring that records relating to care were accurate and kept up to date. This was confirmed by staff supervision records and minutes of staff team meetings which documented good record keeping as a topic of discussion. This showed there were effective quality assurance systems in place to monitor and assess the quality of the service delivered.

The action plan we had asked the provider to submit to show what improvements would be made in regard to the concerns found at our last visit, was submitted to CQC by the specified date. The provider had satisfactory management support in place to make sure staff at Salt Hill Care Centre would be appropriately supported, if the registered was absent.

People and relatives gave mixed comments on whether they were given the opportunity to provide feedback on the quality of the service. Comments received included, "No, but if I ever had a problem I would tell someone", "No", "Not that I recall", "No, I was not asked and I am not aware of any relatives or residents meetings", "Yes, they (management) have asked", "Yes, I have been to a residents meeting. Management (the registered manager) is accessible and always ask if everything is okay when he comes around" and "We have had one once (residents meeting) and were asked what we think have just been given a feedback form."

The registered manager showed us a resident and family survey that had been carried out in December 2017. This captured feedback on all aspects of the service. Where people or their relatives felt further improvements could be made, an action plan put in place was displayed on all units, with specific actions the service had taken. We noted there had been a low response to the survey. We looked at other ways the service sought feedback. We saw complaints and compliments boxes were situated on all units, with the relevant forms within easy reach for people and relatives to complete. We looked at the minutes of a relative's meeting dated 1 July 2017 (only two relatives attended) and a residents meeting dated 18 July 2017. These showed the service actively sought people's views. The registered manager spoke about the challenges faced trying to get more relatives to attend meetings. We noted there had not been a residents and relatives meeting since July 2017. The registered manager acknowledged more work still needed to be done in this area.

The majority of people and relatives were positive about the service and how it was managed. Comments included, "Management is always visible and there is a strong leadership", "They (management) are alright I

suppose. Nothing to improve", "Alright (the management of the service), they run a good ship, I have no complaints", "Management is good and staff look after me well", "It's very good. They (management) run a good home", "It's not good. If staff don't fit they are kicked out" and "(Name of registered manager) is great. They are always visible and accessible."

There is a legal requirement for providers to be open and transparent. We call this duty of candour (DoC). Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 states when certain events happen, providers must undertake a number of actions. We checked if the service was meeting the requirements of this regulation. We found where there were notifiable incidents, the registered manager met the conditions of the DoC.

Staff spoke positively about the management of the service and consistently felt managers were supportive. The deputy manager told us they were equipped to take on their job role and referred to a managerial course they had attended and the support they had received from the registered manager. They told us, "It helped me to gain confidence and to focus not only on residents but relatives, staff and CQC expectations. I have regular meetings with the registered manager, I find him to be very transparent."

Staff told us they found management easy to access and supportive. Comments included, "(Names of registered manager and deputy manager) are visible, accessible and they are keen to listen to what we have say" and "Management are more responsive and the new deputy manager is very supportive." Support and resources were available to enable the staff team to develop and be heard. Staff understood the fundamental need to provide a quality service. Minutes of staff meetings confirmed quality assurance was a regular agenda item.