D R Price Associates Limited

Chataway Nursing Home

Inspection report

19-21 Chataway Road
Crumpsall
Manchester
Greater Manchester
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Tel: 01612055546

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15 September 2016
21 September 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 15 September 2016 and was unannounced. This meant that the provider and staff did not know we would be visiting. We carried out a further announced visit to the home on 21 September 2016 to complete the inspection.

Chataway Nursing Home provides nursing and personal care for up to 26 people with enduring mental health needs. There were 23 people currently living at the home. Three people were in hospital at the time of our inspection.

The manager had commenced employment at the service in August 2016. At the time of our inspection she had applied to be registered with CQC as the registered manager. Following our inspection, she became registered with CQC as 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.

People told us that they felt safe at the service. Positive feedback was received from the health and social care professionals whom we contacted. There were no ongoing safeguarding concerns and staff were knowledgeable about what action they would take if abuse was suspected.

We found that the management of some people's finances did not follow best practice guidelines since designated staff were appointees for certain people. The manager was aware of this issue and told us that there was a back log of appointeeship referrals at the local authority and she was liaising with people's care coordinators to resolve this issue.

Checks and tests were carried out to ensure the safety of the premises. There was a no smoking policy inside the home. There was a designated outside smoking hut for people to use.

Medicines were managed safely. We checked medicines administration records and noted that these were completed accurately.

Risk assessments were in place which had been identified through the assessment and care planning process. This meant that risks were minimised to help keep people safe. Accidents and incidents were monitored and no trends or themes were identified.

Recruitment checks were carried out to ensure that applicants were suitable to work with vulnerable people. This included obtaining written references and a Disclosure and Barring Service check [DBS]. People told us and our own observations confirmed that there were sufficient staff deployed to meet people's needs.

Improvements were required to ensure the design of the premises met the specific needs of people. We have

made a recommendation that the design of the premises meets the specific needs of people who lived at the home.

Not all staff had completed training relating to the specific needs of people who lived at the service, however, plans were in place to source additional training. We have made a recommendation that training is carried out to ensure that staff can meet people's needs. Staff told us that they felt supported. A supervision and appraisal system was in place.

Staff followed the principles of the Mental Capacity Act 2005. Further improvements were required however, to ensure there was documentary evidence to demonstrate how the requirements of the MCA were met with regards to people who had fluctuating capacity because of their mental health illness.

People's nutritional needs were met. The chef and staff were knowledgeable about people's dietary requirements. People had access to a range of healthcare services.

People told us that staff were caring. One relative said, "Chataway is a compassionate caring home." We saw positive interactions between people and staff.
People told us and our own observations confirmed that staff promoted people's privacy and dignity. The manager had ordered dignity screens for all shared rooms to promote people's privacy. We saw evidence that people were involved in their care and treatment.

Care plans were in place which detailed the individual care and support to be provided to people. A life skills coordinator was employed to help foster people's well-being through social inclusion. The service worked in partnership with local community businesses and charitable organisations to help meet the needs of people.

There was a complaints procedure in place. Action to address complaints was documented.

There was an effective system in place to monitor the quality and safety of the service. Various audits and checks were carried out. Actions were taken when any deficits in standards were identified. We looked at the maintenance of records and saw that care files were stored securely. The manager was able to locate all records we requested promptly.

There was evidence that people and staff were involved in the running of the service. Feedback systems were in place to obtain people's views. Meetings and surveys were carried out. One relative told us that they would like to be more involved in the service. Staff told us that morale was good and they enjoyed working at the service.

The manager had submitted notifications to CQC in keeping with their obligations under the Care Quality Commission (Registration) Regulations 2009.

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 told us they felt safe. There were no ongoing safeguarding concerns.

There were sufficient numbers of staff deployed to meet people's needs.

Risk assessments had been carried out to assess risks relating to people.

Recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were required to ensure the design of the premises met the specific needs of people who lived at the home.

Not all staff had completed training relating to the specific needs of people who lived at the service. Plans were in place to source additional training. Staff told us that they felt supported. A supervision and appraisal system was in place.

Further improvements were required to ensure there was documentary evidence to demonstrate how the requirements of the MCA were met.

People's nutritional needs were addressed. People had access to a range of healthcare services.

Is the service caring?

Good

The service was caring.

People told us that staff were caring. We saw positive interactions between people and staff.

People told us and our own observations confirmed that staff promoted people's privacy and dignity. The manager had ordered dignity screens for all shared bedrooms.

We saw evidence that people were involved in their care and treatment.

Is the service responsive?

Good

The service was responsive.

Care plans were in place which detailed the individual care and support to be provided to people.

A life skills coordinator was employed to help foster people's well-being through social inclusion. The service worked in partnership with local community businesses and charitable organisations to help meet the needs of people.

There was a complaints procedure in place. Feedback systems were used to obtain people's views.

Is the service well-led?

Good

The service was well led.

A new manager was in post. Following our inspection she became registered with CQC as the registered manager.

An effective system was in place to monitor the quality and safety of the service.

Staff told us that morale was good and they enjoyed working at the home.

There was evidence that people and staff were involved in the running of the service.

Chataway Nursing 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.

The inspection was unannounced and carried out by two inspectors on the 15 September 2016 and one inspector on the 21 September 2016.

Prior to our inspection, we checked all the information which we had received about the service including notifications which the provider had sent us.

Following our inspection we contacted the local authority commissioning and safeguarding adults teams. We also contacted the local Healthwatch organisation. In addition, we contacted five care coordinators, an independent advocate, a GP, and a psychiatrist to obtain their views of the service. Healthwatch, a GP, the independent advocate and four care coordinators responded to our request for information.

The manager completed a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make.

We approached everyone who lived at the home; six people chose to speak with us. Following our inspection, we contacted two relatives by phone to find out their views of the service.

We spoke with the manager, business manager, life skills coordinator, two nurses, three care staff, the chef and the maintenance man. We examined four people's care plans and checked staff recruitment and training files. We also viewed records relating to the management of the service such as audits and minutes of meetings.

Good

Is the service safe?

Our findings

People told us that they felt safe. Comments included, "Yes it's safe here" and "It's safe." The advocate stated, "Chataway does appear safe." The GP commented, "We have never had any concerns around the safety of the residents." The care coordinator stated, "To the best of my knowledge safeguarding concerns have been raised appropriately and measures have been put in place to safeguard my client."

There were safeguarding policies and procedures in place. Staff were knowledgeable about what action they would take if abuse were suspected. There were no ongoing safeguarding concerns. This meant that people were protected from the risk of abuse.

Safeguarding and whistleblowing was discussed at staff meetings. We read the minutes from the most recent staff meeting. Staff had stated that they were all aware of the safeguarding and whistleblowing procedures. In addition, the minutes stated, "[Name of manager] said that she needed to know if something was happening within the building that wasn't appropriate. The conversation will be treated as confidential" and went on to say her "Door is always open if anyone has concerns no matter how trivial or daft they may seem." This meant that systems were in place to protect people from the risk of abuse.

We checked staffing levels at the service. People informed us that there were sufficient staff deployed to meet their needs. We saw that people were able to access the local community because there were sufficient staff to support them. The manager told us, "The staffing levels allow us to support people to get more involved in the community. If someone is going somewhere for the first time, it's nice to be able to go with them to give them confidence and have a familiar face around." There was always one nurse on duty who supervised the care and treatment of those who had nursing needs relating to their mental health condition. We saw that staff carried out their duties in a calm unhurried manner and had time to provide emotional support and reassurance to those who were upset or required support.

We spent time checking the premises. Accommodation was arranged over two floors linked via three stairways and a passenger lift. There were 19 bedrooms; 12 single and seven twin rooms. There were separate shower, bathroom and toilet facilities on each floor. There was a dining room on the ground floor with facilities for making hot drinks, a main lounge and smaller quiet lounge. There was a no smoking policy inside the home. There was a designated outside smoking hut for people to use.

On the first day of our inspection, we noticed that the window restrictors did not conform to the Health and Safety Executive (HSE) design guidelines. Serious injuries and fatalities have occurred when people have fallen from or through windows in health and social care premises. On our second visit to the service new window restrictors had been fitted. We saw that the flooring was damaged in the main lounge. On the second day of our inspection, we saw that new flooring had been laid.

Checks and tests had been carried out to ensure that the premises were safe, such as electrical and gas safety tests.

We checked the management of medicines. We looked at medicines administration records and saw that these were completed accurately. Medicines were stored safely including controlled drugs which require stricter controls. We spoke with one of the nurses who was knowledgeable about the management of medicines and the types of medicines which people were prescribed. We noted that one person had repeatedly refused their morning medicines. The nurse told us and records confirmed that staff had asked the person's GP to change their morning medicines to the evening because they always took their evening medicines. This meant that systems were in place to ensure that people received their medicines as prescribed.

Risk assessments were in place which had been identified through the assessment and care planning process. This meant that risks were minimised to help keep people safe. Risk assessments were proportionate and included information for staff on how to reduce identified risks. We read that there had been an incident with one person's medicine. A detailed risk assessment had been formulated following this incident. The manager said, "From my point of view I have been through the risk assessments and found that they are detailed. The nurses evaluate them regularly and staff are aware to add things and remove anything that is no longer necessary. We always try and promote positive risk taking in a good way and try to promote residents to be as independent and have as good a quality of life as possible."

We examined staff recruitment. Checks were carried out to ensure that applicants were suitable to work with vulnerable people. This included obtaining two written references including one reference from the applicant's previous employer and a Disclosure and Barring Service check [DBS] to help ensure that staff were suitable to work with vulnerable people. There was a system in place to check that nursing staff were registered with the Nursing and Midwifery Council [NMC]. The NMC registers all nurses and midwives to make sure they are properly qualified and competent to work in the UK.

Requires Improvement

Is the service effective?

Our findings

People told us that staff effectively met their needs. One person said, "The staff are very good here." Comments from relatives included, "The staff know what they are doing" and "I don't know about their training, but it is important that they are kept up to date with government policies to make sure they are not lacking in any area." The advocate stated, "I see it [the service] as effective as they have visited the service users when they have been patients at [name of hospital] due to relapse." The community psychiatric nurse said, "I find that the care is effective and in line with CPA [care programme approach] care plans." CPA is a way that services are assessed, planned, co-ordinated and reviewed for a person with mental health problems or a range of related complex needs.

Many of the staff had worked at the home for a considerable number of years. This experience contributed to the skill in which they carried out their duties. One relative said, "The staff tend to stay and know him well…. they have been there many years and know what they are doing."

Staff told us that training was provided. They explained that most of the training was delivered through watching DVD's. Some staff told us that they would prefer more face to face training. One staff member said, "We watch the same DVD's as we watch every six months." Another staff member said, "The training is getting better, it's been quite basic until now."

We noted that training in health and safety was undertaken, although training in fire safety had lapsed. The maintenance man told us and staff confirmed that this was being addressed and further training was being held. We saw however, that training in people's specific needs such as mental health had not been completed. One staff member said, "We don't do any training on mental illness."

The manager had recognised that this was an issue and was organising further training. She said, "I am currently looking at other types of training… I have also spoken with most staff recently and suggested if there is any training they think they would like in regards to their role if they come and speak to me I will attempt to source this for them… I have also looked into some training around increasing staff knowledge on Active Support Models which I feel may be very useful and will look more into this on my return from leave." Active support is a model of support that aids people to plan the best use of their time, with the correct level of support and engage in all activities that make up day-to-day living.

We did not have any concerns about staff practices and staff were knowledgeable about people's needs, however, further training in the specific needs of people would enable staff to more effectively meet the needs of people who used the service.

We recommend that staff undertake specific training to meet the needs of people, particularly with regard to those with mental health conditions.

Staff said they felt well supported. We noted that regular staff supervision sessions were held and an annual appraisal was undertaken. Supervision and appraisals are used to review staff performance and identify any

training or support requirements.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had assessed whether people's plan of care amounted to a deprivation and had submitted two DoLS applications to the local authority in line with legal requirements.

Most people had capacity to make their own decisions with regards to their care and treatment. We noticed however, that it was not always clear how capacity was assessed for those who had fluctuating capacity because of their mental illness. The manager told us that they would look into this issue.

We checked the management of people's finances. The business manager informed us that they were an appointee for some people living at the home. This is not based on current best practice and had not been decided through a best interests decision making process. An appointee is responsible for managing a person's benefits; paying bills and managing a small amount of savings when a person does not have the capacity to manage their own finances. An appointee can be another individual (friend or relative) or an organisation such as a solicitor or local authority. The manager told us that there was a backlog of appointeeship referrals at the local authority which was confirmed by a member of staff from the local authority's finance team. The manager said that she was speaking with people's care coordinators to resolve this issue. We checked people's financial records and did not have any concerns. The business manager told us, "I balance everything to the penny."

We checked how people's dietary needs were met. People told us that they enjoyed the meals at the home. One person said, "Yes, I like the food." A relative said, "The food is great." People's likes and dislikes were documented in their care plans. We read that one person liked lamb curry and rice" and another person liked apple pie and disliked scrambled egg.

The chef was knowledgeable about people's dietary preferences. He explained that one person was a vegetarian and another person had Halal meat. He also stated, "[Name of person] doesn't like Quorn, he likes egg fried rice. He also doesn't like chips but likes sweet potatoes. I just go and sit with him and find out what he wants." He was also aware of people's nutritional needs and stated, "[Name of person] has lost weight. I give him extra portions and use full fat milk and butter...We also have diabetic ice cream [for those who require a diabetic diet]." He also explained that two people required a soft textured diet. People's weight was monitored and action was taken if any concerns were identified.

We saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example consultants, GP's, community psychiatric nurses and social workers. This meant that staff worked with various health and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met, to maintain their health and wellbeing.

We checked how the design of the service met people's needs. We saw that some people had shared rooms. One of the rooms had a curtain which could be drawn across the middle of the room for privacy and dignity. None of the other rooms however, had any fixed device which could be used to promote privacy. Staff explained that the service had one portable screen which could be used. We spoke with people about this issue and although no one raised any concerns, we considered that the lack of a divide did not always promote people's dignity. Following our inspection, the manager told us that room dividers had been ordered.

One person told us she liked having a bath and a shower. Staff told us however, that they did not have the equipment to assist the person to get in and out of the bath. Following our inspection, the manager told us she had spoken with this person who said they preferred a shower. The manager said that she would monitor this preference and take action if they wanted a bath. There was a bath on the ground floor, which the manager explained could be used by those who could get in and out of the bath independently. She said that most people preferred a shower so they were in the process of turning the ground floor bathroom into a wet room since people who resided on the ground floor had to go upstairs for a shower.

Meals were prepared by the chef. One person told us that she used to enjoy cooking at the service, but there were no facilities to enable her to do this now. Staff laundered people's clothing and bedding with the exception of one person who took her laundry to the laundrette. The manager told us that they were currently looking at ways they could incorporate a cooking and laundry area at the service which people could use to promote their independence.

We recommend that the design of the service ensures that people's privacy, dignity and independence are promoted.

Good

Is the service caring?

Our findings

People told us that staff were caring. One person said, "The staff are very nice." Both relatives were complimentary about the caring nature of staff. Comments included, "The staff are lovely, really caring. They know [name of person] really well…He has gelled with them," "He has been there 20 years and he is the happiest he has ever been" and "They are very caring and compassionate."

Health and social care professionals were also complimentary about the caring nature of staff. The GP stated, "We have provided care to the home for over 20 years and have always found the staff very caring to the patients. They always know their residents and their needs very well…Staff show concern for the residents and their wellbeing whilst respecting their choices." Comments from the care coordinators included, "She was treated with kindness and respect at all times" and "During my visits I feel that the staff engage with the residents appropriately, treating them with dignity and that their needs are addressed. In my interactions with my clients they themselves have not expressed any concerns about their own care and appear happy with the support they receive on a 24 hour basis." The community psychiatric nurse stated, "I find that the staff are caring and treat the residents as individuals."

Interactions between staff and people were patient, friendly, respectful, supportive and encouraging. We saw that one person was cuddling a soft toy. The staff member said, "Ted [toy] goes everywhere, he is well liked isn't he [name of person]. Look he's getting a kiss." We heard another person ask a member of staff, "How do I look?" The staff member said, "You look lovely, are you going out to the shops?"

One person became upset during our second visit to the service. A staff member said, "Did you think of anything to cheer you up? Should I get [name of life skills coordinator] to sing and dance?" We read this person's care plan which stated, "Staff will spend time with [name of person] and give her the opportunity to talk through any fears or worries." We saw that staff did spend time with this individual, reassuring them.

There was a named nurse and key worker system in place which staff told us helped them build a rapport with people. This was confirmed by the relatives with whom we spoke. One relative said, "The staff know [name of person] well, they know his sense of humour." We spoke with a member of staff who said, "We tend to use our relationship with them and we have a laugh. Humour is a good way of doing things." The manager said, "It's like a family, everyone gets on well."

We found the care planning process centred on individuals and their views and preferences. Care plans contained information about people's life histories. We read that one person had been a builder and enjoyed "all kinds of music and television." We read that one person preferred a female staff member to support her with personal care. Staff told us that the person's preferences were respected. This meant that information was available to give staff an insight into people's needs, preferences, likes, dislikes and interests, to enable them to better respond to the person's needs and enhance their enjoyment of life.

Staff actions promoted people's privacy and dignity. Staff were able to explain what actions they would take to ensure people's privacy and dignity was maintained. Staff explained that a portable privacy screen was

used for those people who shared a room. Following our inspection, the manager told us that room dividers had been ordered for all of the shared rooms. The maintenance man showed us around the building. We saw that he knocked on any doors before he entered. He said, "I know the light is off and the door is shut, but I always knock."

We saw evidence that people were involved in their care and treatment. We noted that some people had signed their care plans and risk assessments to state that they agreed with their plan of care. Resident focused interviews' were carried out. The life skills coordinator told us, "These are carried out to find out what they [people] want to do." We read one resident focused interview and under the question, "What activities or hobbies would you like to see here?" The person had stated that they were "Past all that!" This meant there was a system in place to involve people in their care and treatment and find out what was important to them.

Relatives said that they felt involved in people's care and treatment. One relative commented, "There is the opportunity to work together and for members of the public [relatives and friends] to get involved and work with staff to continue to care for their loved ones." Another said, "They will ask me what I think." One relative felt they would like be even more involved in their family member's care. We spoke with the manager about this feedback. She told us that the person preferred to have care reviews by themselves with staff at the home and their care coordinator. She said that she would monitor the situation and continue to ask the person whether they would like anyone else to attend their care reviews.

People could access advocacy services. Advocates can represent people who are not able to express their own views and wishes. We contacted an independent advocate who had been involved with several people. She told us, "They are certainly caring and keen to have service users back at home as they feel it is in the service users' best interests to return to the home [from hospital]."

Good

Is the service responsive?

Our findings

People told us that staff met their needs responsively. One person said, "It's got a lot better, you used to just sit in an arm chair." Both relatives told us that the service was responsive to their family member's needs. Comments included, "They have got a lot better at communicating with me…They also have structures in place and will phone me when [name of person] has not been taking their medicines" and "I think they are okay, [name of person] has their ups and downs, but they do look after them well."

We conferred with health and social care professionals about the responsiveness of staff. The advocate told us, "On one occasion [name of staff member] informed the nursing medical team that a particular patient was at his best and suggested the patient return to the home rather than remain on the ward any longer, this enabled the patient to be discharged sooner." We spoke with a care coordinator who said, "I placed one of my citizens there and they have worked wonders with them. Their challenging episodes are now rare and it's down to their expertise and communication. They will drop me an email or phone me if they have any issues. I don't have any concerns… I do signpost others to the service. I can't fault them." Comments from other care coordinators included, "Concerns have been raised when necessary by staff in relation to presenting risk to clients or to themselves and staff have passed these concerns on and contacted the consultant when felt necessary to review a client's mental state" and "I feel confident in saying that the home was responsive when one of my clients experienced a relapse of their illness earlier this year and they were able to respond to the challenging behaviours they presented with at that time." A community psychiatric nurse stated, "I find that the staff are aware of risks related to individual residents and are quick to inform me of any issues." The GP stated, "They use our service appropriately. If carers are sent with residents for the [GP] surgery visits, they always have the information needed to hand and we are aware that information is handed over appropriately and promptly."

We read three people's care plans and noted that these were detailed and person- centred. This is when treatment or care takes into account people's individual needs and preferences. Each person had a care plan for their mental health and physical needs. These gave staff specific information about how people's needs were to be met. They also detailed what people were able to do to take part in their care and to maintain some independence. People therefore had individual and specific care plans in place to ensure consistent care and support was provided. The care plans were regularly reviewed to ensure people's needs were met and relevant changes were added to individual care plans.

We read that one person had diabetes. We noted however, that the care plan did not specify when medical advice should be sought when the person's blood sugars were high, to ensure consistent treatment was provided and timely medical advice sought. The manager told us that they had contacted the diabetes specialist nurse with regards to this issue and this had been addressed.

The life skills coordinator completed 'Recovery Star' assessments with people. The Recovery Star is a visual aid to help people measure their own recovery programme in 10 areas. These included living skills, relationships, social networks and identity and self-esteem. The Warwick-Edinburgh Mental Well-being Scale was also used to assess people's mental well-being. This meant that research based tools were used to

monitor people's health and well-being and ensure that timely action could be taken if concerns were noted.

People told us that their social needs were met. One person said, "I can go out when I like." A relative said, "They are good - there is enough going on. He is independent and gets the bus to Bury."

A life skills coordinator was employed to help foster people's well-being through social inclusion. He supported people with goal setting and helped develop their interests and independence. There was a three week activities rota in place. This included activities such as, "Music nostalgia afternoon, mini football penalty shoot-out, bingo, karaoke evening, arts and crafts and expression through discussion sessions."

The service worked in partnership with local community businesses and charitable organisations to help meet the needs of people. These included the local college, leisure centre, a gardening project and a cookery group. The manager said, "We liaise with some external agencies who offer activities, work placements and some education and it is planned that we encourage and support more of our residents who are able to link into these and become more involved. We are also interested in supporting residents with healthier lifestyles by encouraging exercise and ensuring all attend physical health appointments."

People accessed the community on the days of our inspection. A staff member said, "We go all over, to the park, shopping and she loves to sing and dance." There were board games and bingo also organised. There was much laughter during a game of Jenga. A staff member said to people, "That was fun wasn't it, should we do it again?"

There was a complaints procedure in place. People with whom we spoke told us that they knew how to complain. We saw that complaints had been addressed in line with the provider's complaints procedure. Records of compliments were also maintained. We read a recent compliment which was from a local authority contracts officer which stated, "I received a compliment from the social work team at [name of team] to all the staff at Chataway on the engagement from staff to service users. It's quite refreshing to receive good comments."

Good

Is the service well-led?

Our findings

Chataway nursing home was originally established in 1992 and was acquired by the current provider in May 2004.

There was a manager in post who had commenced employment in August 2016. At the time of our inspection, she had applied to register as a registered manager with CQC in line with legal requirements. Following our inspection, she became registered with CQC as a registered manager. She had been a qualified mental health nurse since 2005 and had over 26 years' experience in mental health. She was currently undertaking her level 5 Diploma in Leadership and management.

Staff explained that there had been three different managers employed at the service over the previous 18 months, including the present manager. They said that this had led to some degree of unsettlement. All staff however, spoke very highly about the current manager. Comments included, "I am very happy with our new manager," "[Name of manager] is brilliant," "She [manager] is far better, she listens to our ideas" and "[Name of manager] is very approachable, hands on and very good. She is always [working] on the floor." The manager had only been in post for a short period of time. She was fully aware of all the issues that we had found such as training and the design of the premises and was addressing these. The manager told us, "I make sure I spend time [working] on the floor. I enjoy spending time with the residents. There's no closed doors, my office is always open."

Health and social care professionals and relatives with whom we spoke were complimentary about the management of the service. The GP stated, "I have always felt that the home was well led with effective managerial staff." A relative commented, "It's well led."

Staff told us that they were happy at the service. Comments included, "I am very happy working here," "I love it here," "We all get on well," "We have a willingness to learn and put anything right, which is the most important thing," "We're a team and we all have a role to support the clients" and "I am very happy working here. We all work well together as a team."

All areas of the service were audited and checked with regards to quality and safety. Accidents and incidents were monitored and no trends or themes were identified. We read the minutes from the latest health and safety meeting. These stated, "There are no major reoccurrences of incidents." Care plan audits were carried out. One recent care plan we viewed had been audited and the manager had stated, "83% compliant. This file needs updating." We noted that the file had been updated and reviewed since the audit had taken place. The manager told us, "We always make sure we follow through."

One of the directors carried out an audit every month which took two days to complete. The manager told us, "She is very approachable and staff and residents know her and feel able to raise any issues." This was confirmed by staff with whom we spoke.

There was an effective staff communication system in place. 'Onesie' meetings took place every day at 1pm.

The manager told us, "They are basically a catch up for staff during the 12 hour shift." We attended one of these meetings. Staff discussed people's physical and mental health and any actions that needed to be completed. We heard the nurse ask the care staff about a urine sample that was needed for one person and another person had had their bloods taken to check that they were receiving the correct dose of medicine. Staff also discussed different methods of dealing with certain people's behaviours which could be considered as challenging.

Staff meetings were carried out. Staff told us that they felt able to raise any issues and their feedback would be acted upon. We read the most recent staff meeting which was carried out on 13 September 2016. Record keeping, activities and training were discussed.

Annual surveys were carried out. We noted that people stated that they had been unclear about the complaints procedure, requested more social activities and raised issues about the laundry. The manager gave feedback about these areas in the most recent newsletter. She stated, "Unsure of the complaints procedure – there are copies of the complaints procedure up on various notice boards throughout the building. . .Alternatively, there is a comments box in the front entrance where any comments, complaints or compliments will be dealt with. Some problems with the laundry were mentioned – please can residents raise these issues on a daily basis to be dealt with then and there. More social activities, a number of residents scored activities and social excursions low. Please can residents take any ideas for future activities to the meeting tomorrow." This meant there was a system in place to obtain and act on people's feedback to improve all aspects of the service.

Meetings for people were also carried out. We read the minutes from the most recent meeting. These stated, "Please think of some meal options you would like to have or try for the new quarter. [Name of manager] gave a couple of options; chilli con carne, curries – no comments made from residents. [Name of staff member] then went around the room asking residents individually their own personal preferences." We read that one person asked for apple pie, another fish and chips. One person said, "I want to go to the exercise group again." The staff member said, "It's the summer holidays at the minute, but when it restarts we will look to re-attend." An action plan was attached to the meeting minutes. This stated, "Talk to chef about autumn menu options and residents ideas for meal options" and "Blackpool trip arrangements." The staff member responsible and target date for completion and date completed were included. We saw that both action points had been completed. This meant that people's opinions were sought and action was taken to address any issues raised.

Relatives with whom we spoke informed us that newsletters were sent and surveys carried out. One relative informed us that they would like to be more involved in the running of the service and have access to information relating to the home's policies and procedures. We informed the manager of this feedback and she told us that this would be addressed.

We looked at the maintenance of records. We saw that care files were stored securely and the manager was able to locate all records we requested promptly.

The manager had submitted notifications to CQC in keeping with their obligations under the Care Quality Commission (Registration) Regulations 2009.