Borough Care Ltd

# Marbury House

**Inspection report**

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Date of inspection visit: 22 & 23 September 2015
Date of publication: 13/01/2016

## Ratings

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

## Overall summary

This was an unannounced inspection of this location. This inspection took place on 22 and 23 September 2015.

The service was previously inspected on 11 September 2013 when no breaches of legal requirements were found.

At the time of the inspection the manager had submitted her application and was waiting to be interviewed. Following the inspection we received confirmation that the manager had been interviewed and registered. 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. A home manager was in place and an application to become registered had been submitted to the Care Quality Commission (CQC).

# Summary of findings

Marbury House is one of twelve care homes owned by Borough Care Limited, a not-for-profit registered charity. The home is registered to provide intermediate care and accommodation for up to 41 people who require care, support and rehabilitation following hospital treatment.

The home is a two storey building situated on the Marbury housing estate in Heaton Chapel Stockport near Manchester. There are forty single bedrooms located over two floors, ten of which have an en-suite toilet. The first floor can be accessed via a passenger lift. In addition there are communal bathrooms, toilets, rehabilitation kitchens, lounge and dining areas available in the home.

Some of the support services at Marbury House were provided by an intermediate care team who delivered services such as nursing care and occupational and physiotherapy.

An Intermediate Care team is a partnership of Health and Social Care enablement staff working together to prevent admissions or readmissions to hospital and facilitate timely hospital discharge. At the time of our visit 37 people were receiving intermediate care and support at Marbury House.

Some staff when asked were not confident about their duties and responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The home manager advised us that she would arrange further staff training to help make sure staff confidence was increased in this topic.

Matters giving rise to concern identified at a coroner's inquest in 2014 had been addressed and actioned by the provider to prevent the risk of future deaths occurring in similar circumstances. The provider had set out and followed an action plan for staff to undertake training to help make sure they were clear about and fully understood what constitutes a reportable incident. All of the organisations care home managers also received awareness training in the reporting of such incidents. The provider had also taken action to make sure that the door closers on all doors were made safe and were in good working condition.

This service was safe and people told us that they felt safe. Care plans highlighted the areas of support needed in detail and had associated risk assessments. Medicines were managed safely. We saw that a cleaning system in place helped to make sure the home was clean and there were no offensive odours apparent during our visit.

There was sufficient staff that had been recruited safely. Care staff had all received a thorough induction, training and support when they started work at the service and fully understood their roles and responsibilities, as well as the values and philosophy of the home. They understood what was meant by safeguarding and had undertaken training in adult safeguarding.

People were provided with care by staff who supported them to live as independently as possible. Staff working in the home understood the needs of the people who lived there and knew how to make sure the care provided to people followed best practice and written care plan instructions. We found that people's care was delivered consistently by a multidisciplinary team of workers who knew how to support people and meet their assessed care needs.

People spoken with told us that the service was caring and we observed staff to be caring. We saw good relationships between individual staff and people who used the service and we saw that care was provided with kindness. Staff were respectful when speaking with people and maintained their dignity. We saw that staff responded promptly when people required assistance.

We found that the service was responsive to people's individual needs and the care plans we looked at were person centred and up to date. Care instructions about how staff should support people's needs were detailed and clearly written. People who used the service were engaged in meaningful activity to promote their wellbeing.

Staff were following the principles of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) when they cared for people who lacked the mental capacity to make their own decisions. Advocates were available to help people to support people in expressing their views where necessary.

Quality monitoring audits had been carried out for the service looking at medicines, the care provided, mealtimes and choice and involvement and records used to manage the service.

# Summary of findings

The provider encouraged feedback from people using the service and their families. Feedback was given in the form of complaints, comments and compliments. A care plan quality monitoring system in place was also used to help make sure the service met the overall requirements under the regulations.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Good

The service was safe.

There was an effective recruitment and selection procedure in place and appropriate pre-employment checks helped to make sure that new staff are suitable to be employed in a role supporting vulnerable people.

Individual risks to people's safety were appropriately assessed, managed and reviewed.

Medicines were stored safely and records were kept for medicines received and disposed of; this included controlled drugs (CD's).

**Is the service effective?**

Good

The service was effective.

Care staff had all received a thorough induction, training and support when they started work at the service and fully understood their roles and responsibilities, as well as the values and philosophy of the home.

Staff had undertaken training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) however further training for some staff was planned in this area to the make sure staff were fully aware of their duties and responsibilities in this area.

There was a structured staff supervision plan in place which was being followed regularly. Future supervision dates had been planned to make sure staff were continually supported in their work.

**Is the service caring?**

Good

The service was caring.

The provider used a recognised end of life programme for people nearing end of life and staff were aware of the resources available to people, such as district nurses and General Practitioner's (GP's) when they might require such care.

Staff showed warmth and friendship to people using the service and they spoke to them in a kind, comforting and sensitive manner. This helped to make sure people's wellbeing was promoted.

**Is the service responsive?**

Good

The service was responsive.

Care plans were clearly written and were person centred. Consent forms had been signed by the person to agree to the care being delivered.

Care plans seen had been completed to help make sure the people's lifestyle, routines and beliefs would be followed by staff during their stay at the home.

Daily records and notes made by staff helped to make sure that specific instructions about the persons care were being followed and responded to in a timely way.

# Summary of findings

**Is the service well-led?**

Good

The service was well-led

Care plan audits were carried our regularly to help make sure that written instructions about people's health, wellbeing and the way the service was being run were accurate and effective.

A care plan quality monitoring system in place was also used to help make sure the service met the overall requirements under the Health and Social Care Act 2008 Regulations.

# Marbury House

**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 service was previously inspected on 11 September 2013 when no breaches of legal requirements were found.

This inspection took place on 22 and 23 September 2015 and the first day was unannounced.

The inspection was carried out over two days by one inspector. We visited this location because we wanted to check if the provider had taken the necessary action in response to a coroner's Regulation 28 report to prevent the risk of future deaths occurring in similar circumstances.

Before we visited the home we checked information that we held about the service and the service provider about the care provided in the home. No concerns had been raised by healthcare and the local authority since we completed our last inspection.

On this occasion we did not ask the provider to complete a provider information return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

During the inspection we saw how the staff interacted with people using the service. We also observed support and rehabilitation being provided in some communal areas.

We spoke with two people who used the service, four relatives, the cook, four senior health care assistants (SHCA's) the home manager, the office administrator, two registered nurses (RGN's) one social worker and seven health care assistants (HCA's).

We walked around the home and looked in 10 bedrooms. We looked in all of the communal areas, the kitchen and communal toilets and bathrooms. We reviewed a range of records about people's care and support which included the care plans and medicine records of four people, the staff training and supervision records for five staff employed at the home, and quality monitoring records that related to how the home was being managed.

Good

# Is the service safe?

## Our findings

Two people we spoke with told us they felt safe and had no complaints or concerns about the care provided. One person said, "I feel at home, oh yes it's very safe here and I feel protected". A relative spoken with said, "Everything is fine and he [relative] is safe where he is".

Matters giving rise to the concern identified at a coroner's inquest in 2014 had been addressed and actioned by the provider to prevent the risk of future deaths occurring in similar circumstances. Following the inquest and in response to the coroners Regulation 28 report the provider had set out and followed an action plan for staff to undertake training to help make sure they were clear about and fully understood what constitutes a reportable incident.

As a result of the coroner's Regulation 28 report all of the Borough Care home managers received awareness training in how to report a serious incident. The provider had also taken action to make sure that the door closers on all doors in the home were made safe and were in good working order.

We examined records of accidents and incidents in relation to people using the service and saw they were clear and up to date. Where such incidents had occurred the provider had introduced risk assessments to mitigate the risk reoccurring. We saw that appropriate authorities such as the local authority adult safeguarding team and the Care Quality Commission had been notified in a timely way of such events when necessary.

There was a recruitment and selection procedure in place that was in line with the current regulations. We looked at six staff recruitment files and found that all of the staff files contained appropriate documentation to demonstrate that staff had been recruited in line with the regulations including the completion of a disclosure and barring service (DBS) pre-employment check and receipt of two appropriate references. Such checks help the registered manager and provider to make informed decisions about a person's suitability to be employed in any role working with vulnerable people.

Five staff spoken with told us they had undertaken an employment induction before they were able to work at the home unsupervised with people. The manager and staff told us there was always enough staff on duty to meet peoples assessed needs. Observations of the staffing levels and examining the staff rota confirmed the staffing numbers were sufficient as described by the staff and the manager.

We saw that disciplinary procedures in relation to staff had been used when necessary. Appropriate action taken to periodically monitor staff performance through weekly supervision sessions and staff training helped to make sure that staff were well supported to carry out their roles.

There was a safeguarding procedure in place which was in line with the local authority 'safeguarding adults at risk multi agency policy' and staff spoken with knew how to access the policy. We looked at records that showed the provider had procedures in place that helped to ensure any concerns about a person's safety was reported to the appropriate authorities. This included any staff disciplinary action. The manager had identified where there were concerns about people's safety, these concerns had been recorded and the appropriate authorities had been alerted where appropriate.

Discussions with staff about risks to people such as falls showed they understood how to keep people safe. Five staff spoken with understood the purpose of the home's safeguarding procedure, and were able to describe the different types of abuse. Staff spoken with told us they knew to be vigilant about the possibility of poor practice by their colleagues through the use of the homes whistleblowing policy. Whistle blowing is when a person raises a concern about a wrongdoing that may place a person at risk of harm in their workplace.

Staff spoken with advised us of the process they would follow when reporting any concerns about people's safety to the home manager. They were clear about how to report safeguarding concerns in a timely way to external authorities such as the local authority and the Care Quality Commission. From the four care files we looked at we saw that individual risks to people's safety had been properly reviewed and risk assessments identified how risks would be managed doing all that was reasonably possible to mitigate any such risk.

The home had a medicines policy and procedure. Medicines were stored safely and records were kept for medicines received and disposed of; this included controlled drugs (CD's). We observed part of the afternoon medicines round and saw that medicines were

Good

# Is the service safe?

administered following the homes procedure by a senior health care assistant (SHCA). We looked at the medicine records for four people and found the records to be completed accurately and were up to date. When we asked a person and two relatives if medicines were administered on time they confirmed they were. During the medicines round we saw people were offered their medicines in a sensitive and unhurried way.

We saw staff wearing uniforms, aprons and gloves to prevent the risk of cross infection when carrying out their care duties. During a tour of the home we looked at a sample of armchairs, wheelchairs, walking frames, bedside protectors and pressure relieving equipment and saw that these were clean, well maintained and safe. We found communal bathrooms had been cleaned regularly throughout the day. Handwashing soap and gel were readily available in shared bathrooms and toilets. Overall there were no offensive odours apparent and the premises was clean and suitable for the intended purpose.

We saw that some areas of the home looked dated and required redecorating however these areas were safe and clean and the home manager had a refurbishment continuity plan in place to address the decor issues.

We looked at a lounge/ dining area on the first floor which had been newly decorated and new furniture was to arrive within the coming days. It was apparent that the provider had tried to make sure that the premises were decorated and maintained to a good standard so that the facilities in the home met the anticipated needs of people who would use the service.

Staff kept entrances and exits to the home clear and secure to so that they could monitor who came in and left the building. This did not restrict people's movements and records showed people could leave the home with appropriate supervision and safeguards in place if they wanted to.

Good

# Is the service effective?

## Our findings

People spoken with told us they felt the staff were skilled enough to meet people's needs and one person said, "they know what they're doing here; they have everything sorted out". They made positive comments about the meals served such as, "The food is nice", "there is plenty to eat, I can have whatever I want; there is never a problem" and a relative said, "my husband said the food's lovely".

A person told us about the medical attention she received at Marbury House, "I get physio and the home's GP comes to see me; I feel at home here". Two relatives told us that they felt people were able to see their GP whenever they needed to and were enabled to see other health care professionals such as nurses and occupational therapists as part of their rehabilitation plan.

We looked at care records that showed people were being provided with enough fluids during the day to keep them hydrated. One person said, "I can have a drink whenever I want, no problem". We saw that where people needed to have their fluid intake and output monitored, this was being recorded by staff. Where a dietician had made recommendations for staff to follow, we saw records to monitor and maintain people's weight had been completed.

Meals were provided by 'Dine', an outside catering company providing hot and cold meals based around an 'eat well live well' ethos. We looked in the kitchen and spoke with the cook who told us about the system in place that helped make sure people received the correct diet at all times. They said, "at the moment we have seven different diets and I make note of them on the kitchen notice board. We can provide softer diets and liquidised, but nobody here requires that sort of meal at the moment. We have snack boxes for people who are diabetic and those who are at high risk of weight loss. We also provide a packed lunch for people who attend a hospital appointment because we never know how long they'll be waiting at the outpatients department". We saw that the meal served on the first day of our inspection looked appetising, balanced and nutritious.

From our observations people who used the service had adequate nutrition and hydration to sustain good health. All of the people receiving care at Marbury House had their nutritional needs assessed when they moved into the home. We saw where it was noted that a person required additional support with their dietary intake the manager would contact the dietician service to review and risk assess the person's nutritional and hydration needs. We saw nutrition and hydration needs were being monitored regularly and reviewed during the course of the person's stay at the home.

From the seven staff spoken with, all of them confirmed they had received a staff induction at the start of their employment at Marbury House. Four staff in particular confirmed their induction and collectively said, "we had to shadow a senior (SHCA) for about three days", "our probationary period lasts for three months" and "our probationary is done in-house", "we've done a lot of training; there's always lots of training", "we do our mandatory training like fire awareness, food hygiene, infection control moving and handling, there's loads".

Training such as this helped to make sure their knowledge, skill and understanding was up to date and effective. Staff told us and through information held on the staff training and development plan we saw that staff received regular training in topics such as dementia awareness, equality and diversity, and end of life care. The registered manager provided documentary evidence that all of the staff team had undertaken appropriate training which was updated regularly for staff to develop their skills and knowledge in specialist areas such as pressure area care.

Whilst we saw records that showed staff had undertaken training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), through discussion with the staff we noted that not all staff were confident about what to do when these restrictions were in place. The manager had a clear understanding about this legislation. These safeguards protect the interests of vulnerable people and help to make sure they are given the care they need in the least restrictive way. The home manager advised us that further training in the MCA and DoLS would be provided to make sure staff are confident of their duties and responsibilities in this area. At the time of our inspection nobody was being protected by a DoLS.

There was a structured system in place to provide regular supervision to staff. The home manager, deputy and senior health care assistants (SHCA's) were responsible for providing supervision and annual appraisal for staff working at the home. From the six staff records we looked at we saw these sessions were taking place regularly. We

Good

# Is the service effective?

saw that future supervision dates had been planned to make sure staff were regularly supported in their work. Staff made positive comments about their supervision and appraisal and said, “roughly supervision is every six weeks”, “it’s ok, we don’t mind it” and “it helps”. We saw records to confirm that the home manager also received regular supervision and an annual appraisal.

From our observations of the care being provided we saw that workers from the multidisciplinary team such as nurses, occupational therapists, health care assistants, physiotherapists and community rehabilitation workers referred to practices that were based on up to date best practice. Appropriate clinical research and medical advice was followed to make sure that the care provided was relevant and effective. We observed care staff supporting people to use the aids and adaptations recommended by an appropriate professional such as an occupational therapist. Equipment such as walking aids, standing hoists, hand rails and wheelchairs were seen to be in use to help make sure that people’s individual needs were being met in accordance with the instructions in their needs assessment.

When we toured the home we found the décor in some areas such as corridors, bedrooms, communal bathrooms and toilets was in need of redecoration. We found wide corridors were made accessible for people using a wheelchair or mobility aids and this helped to promote their independence around the home. Communal bathroom and toilets were spacious enough to manoeuvre wheelchairs and hoists. Raised toilet seats, handrails and non-slip flooring were in place to further maintain people’s independence. We saw that the premises were clean, warm and well maintained despite some areas of the home awaiting redecoration. This helped to make sure people’s wellbeing was promoted. During our inspection we noted that some garden maintenance was being carried out to help make sure the area was safe for people to use.

Good

# Is the service caring?

## Our findings

People spoken with made positive comments about the care and support provided to them at the home. Three relatives spoken with said, “I’ve found them very good; I’ll be taking something [gift] into the girls when he [relative] leaves”, “the care he [relative] receives is top notch; he’s always happy, the staff take an interest, a real interest in him”, “I feel at home here; I want to go home but the staff make it homely” and “staff are kind; they never shout, always kind”.

From our observations during the inspection we saw staff caringly respecting people and making sure people in the home were comfortable. We saw staff were attentive to people’s needs and responded to people’s requests with patience, kindness, warmth and friendship. Staff were heard speaking to people in a kind, comforting and sensitive manner which helped to make sure people’s wellbeing was promoted. We saw staff updating people’s care notes in an office or a quiet space in one of the communal spaces. We saw that staff made sure any written records or discussions about people were carried out discretely to protect people’s privacy.

There was a company policy and procedure about end of life care and the home had adopted the ‘six steps’ end of life programme. This is a programme to consider how the needs of people using the service and their relatives could be met and at what stage care and support should be delivered nearing a person’s end of life. The home manager told us that nurses from the intermediate care team were trained in delivering end of life care and other professionals such as a GP would be involved to help make sure people could be cared for at the end of their life in the place and manner of their choosing.

Staff told us they had been trained in how to respect people’s privacy and dignity, and understood how to put this into practice by making sure that any care intervention would be carried out away from communal areas wherever possible. Two health care assistants said, “I treat people here as I treat my own family, with respect” and “they [people] need us here; it’s good to see them recovering and moving back home”.

Where necessary people were assessed by a social worker to determine any advocacy representation to help make decisions about their health and wellbeing. Advocacy services are designed to support people who are vulnerable or need help tomake informed decisions andsecure the rights and servicesto which they are entitled.

Throughout the inspection we noted that people were accorded a standard of care and attention which respected their individual preferences, privacy and dignity, recognised their diversity and promoted their independence. We saw staff actively listening, showing kindness and friendship to people and encouraging them to make informed decisions about their day to day actions such as choosing meals, where they wanted to sit in shared spaces and requests for staff to provide people with mobility support.

It was apparent that people using the service and their wellbeing were a central focus and were the priority over the home, the management and staff. Care plans were written to help make sure people experienced care that was empowering regardless of the person’s ability and consent forms had been signed by the person to agree to the care being delivered. We saw staff showing patience and empathy to a person who required assistance with his mobility. For example we observed the staff walking at the person’s pace whilst using words of encouragement at each step taken. This provided the person with confidence to reclaim a degree control over their life whilst in a caring and protective environment.

Good

# Is the service responsive?

## Our findings

Four people told us about the way in which the care was being delivered and said, "I read his [relative] notes and the staff are definitely approachable; the care notes are clear and they [staff] seem to know what they are doing", "they help her [relative] and she doesn't complain", "staff are helping him [relative] on his way; he is doing very well and they [staff] are good at supporting him".

We saw themed reminiscence items had been placed on corridor walls to prompt thoughts, memories andconversation that would naturally arise through touching and seeing familiar objects.

We looked at the care records that belonged to four people and saw that each had a care plan that had been written to make sure people received appropriate care, treatment and support to meet their needs and protect their rights. The care plans we looked at were clearly written and centred on the person as an individual. The care plans seen showed that people had received a needs assessment before they moved into the home to help make sure that care would be delivered in response to those needs.

From the four care plans we looked at each showed the preferred name to use to address the person, information about their previous employment, family life, social interests, friends, hobbies, pets and extended family. Another section of the record titled 'things I can do' described the person's personal appearance, waking, night, toilet and hygiene routines. A 'getting to know me' section contained details that highlighted what was important to the person, who supported the person and steps to enable the person to stay in control of their life. 'Things to remember' and 'triggers' for areas such as nutritional risks, dehydration prevention, leaving the building, favourite foods and special diets prompted the staff to check that these areas were prioritised to ensure safety and effectiveness of the care being delivered. Sections of each care plan had been completed to reflect the person's lifestyle, values, behaviours, routines, diversity and beliefs and made clear the areas that both day and night staff should follow to provide care that was person centred.

The care plans we examined included up to date information on risk assessments for falls, personal safety, mobility and nutrition. Records showed that people had regular access to healthcare professionals, such as GPs, dieticians and nurses. We saw records that confirmed nutritional risk assessments had been completed by an appropriate professional to help reduce the risk of people receiving unsafe or inappropriate care. Care plan records and risk assessments had been reviewed monthly or more frequently, if people's immediate needs required monitoring. From the four care plans we examined, we discreetly observed care and support being provided to each person in line with the instructions noted in their care records.

The manager told us that where people had been admitted to Marbury House from hospital with less than six hours-notice, some care plans were not fully completed because pre admission information had not been transitioned to the home with the person. The manager said, "we try to get as much information as possible about the person before admission, but it isn't always possible". Although the home's needs assessment record was not designed to work alongside the assessment record used by the intermediate care team, the manager told us that no person's equipment, care or treatment had ever been delayed because of the current assessment form used, she said, "our care plans are person centred so we use the care plan as a needs assessment tool as well". We noted that assessment arrangements in place were suitable to meet people's needs.

We saw staff checking on particular people where risks had been highlighted such as risk of falls. We saw that written care instructions were responsive to people's individual characteristics so that their needs would be met based on best practice and professional guidance. Daily records and notes made by care staff helped to make sure that specific instructions were being followed and responded to by members of the intermediate care team.

There was a complaints procedure in place which was available to people who used the service and their relatives. People spoken with knew their comments concerns or complaints would be taken seriously and acted on by the manager. From the records we looked at any complaints or comments made had been addressed immediately and action taken followed the homes procedure for dealing with comments and complaints.

Good

# Is the service well-led?

## Our findings

When we visited Marbury House the provider did not have a registered manager in place and had been without a registered manager since October 2014. At the time of the inspection the home manager had submitted an application to the Care Quality Commission (CQC) to become the registered manager. Following the inspection we received confirmation that the home manager had been interviewed and registered.

The Borough Care company values underpin how the manager operates the service and is committed to routinely and proactively communicating what they are doing at the home by involving their staff and stakeholders where possible in developing better ways of working and seeking feedback on their performance.

There was a clear management structure at the home. Staff told us they knew the role and responsibilities of the management team. They told us that the managers were approachable and were always present in the home.

We saw that there were corporate policies and procedures in place to support the daily running of the home and help to make sure that staff were clear about their duties when they were involved with all aspects of people's healthcare and wellbeing. Staff were able to demonstrate through discussion that they knew their responsibility to make sure that the care being provided to people was safe, responsive and effective.

The provider used an existing in house system to monitor the quality and performance of the service and service user satisfaction. This system included the maintenance of monthly audits such as monthly care planning reviews and collecting data for monitoring and mitigating the risks relating to the health safety and welfare of people using the service, staff and visitors.

The home manager collected weekly data by checking that each person had a named key worker, that care plan records were in good order and included the relevant up to date information to meet people's needs and keep them safe.

Weekly multi-disciplinary meetings were used to plan and agree new admissions to the unit and check that people already using the service were receiving the care and support that met their identified needs. This process was in place to make sure people were enabled to move back to their own home within an agreed timescale which was usually after a period of three months of receiving care at Marbury House. Further information about how care was delivered, medicines management, the mealtime experience, people's choice and involvement were monitored weekly and information gathered was audited monthly.

We examined the findings from two care plan audits that had been completed by the provider's quality assurance team in September 2015. The audit checked a sample of medicine records and medicine stock, call bell response times and the written details in people's care plan. The audit had identified a minor shortfall where a person's favourite food had not been completed on admission to the home. The manager told us that the person had only just moved into the home a day earlier and was unable to give them this information at that time. The manager said, "it's a bit too soon to get information from the person when they first move in here. People are tired and just want to get settled, so we 'll ask them later today or tomorrow, when they feel they've settled more".

We looked at a copy of a night shift audit which had been completed in May 2015. The record showed that the manager had made an unannounced visit to the home at 5.30am to check on staff routines, speak to people using the service if they were awake, speak to staff, and to undertake individual supervision with the night staff. Any audits we looked at showed that information gathered was evaluated and flagged up to the head office for immediate action. We saw that areas identified for improvement such as bedroom and home redecorating was included in an action plan which formed part of the ongoing services development plan. The service development plan included a priority list of areas of the home to be redecorated following the refurbishment of a lounge dining area in the home. We saw that any other actions required such as a staff signature missing from a person's initial assessment form had been noted with timescales and met.

A resident's forum was held on 10 September to feedback to people using the service about the actions taken following an earlier audit. Completed actions were noted on the home's notice board under the heading "You said - we did". We saw that where people had made a requested for a particular service such as menu and bathing/ showering preferences the notice confirmed that people's

Good

# Is the service well-led?

requirements had been acknowledged and actioned. However some people who had made such requests previously had since been discharged from the service and we were unable to check their care files to confirm this further.

The local authority health protection and control infection unit had carried out an infection control assessment in September 2015. The assessment looked at areas such as care management, care practices, communal areas, resident's rooms, and toilets. The assessment found some minor shortfalls around the cleanliness of the communal toilets, however this was resolved immediately during the assessment visit. Overall the results from the assessment visit showed and acknowledged that parts of the home were already undergoing a refurbishment and phased redecoration was taking place in areas of the home such as the sluice which would be retiled in October 2015.

Three relatives spoken with said, "The manager is very approachable; yes I'd say the home is well led; everybody [staff] is lovely", "she [manager] seems to know what she is doing, she's really helpful and approachable, the staff are very good and very skilled" and "I can go to the manager or deputy at any time; if I need to know anything they ring me or we have a chat before I go to see him [relative]".

Matters giving rise to concern identified at a coroner's inquest in 2014 had been addressed and actioned by the provider to prevent the risk of future deaths occurring in similar circumstances. Following the inquest the provider had set out and followed an action plan for staff to undertake training to help make sure they were clear about and fully understood what constitutes a reportable incident.

Records showed that the manager recorded and investigated incidents that happened in the home and had taken the appropriate action to reduce the risk of them happening again. The provider had notified us of any incidents and events as required. Risk to people was minimised because the systems in place for monitoring risk were effective.

We sat in on a multidisciplinary team meeting and a staff meeting and saw that information was shared and feedback sought from the staff in attendance at the meetings. Any feedback was noted and used to make any necessary changes to the service provided to people at the home. The manager informed staff through their team meeting about any changes that had been implemented in response to risks. Communication between the manager and staff was seen to be effective and systems in place helped to maintain this.