Minster Care Management Limited

Abbeywell Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We completed an unannounced inspection at Abbeywell Court on 23 and 24 November 2017. At the last inspection on 24 March 2015 the provider was meeting the Regulations and we rated the service as 'Good'.

Abbeywell Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Abbeywell Court accommodates up to 45 people in one adapted building. Abbeywell Court provides support for people who predominately have a physical disability and/or a mental health condition such as dementia.

There was a registered manager at the service. 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.

We found that some medicines were not always administered as prescribed.

Some improvements were needed to ensure that unexplained bruises were investigated and reported to the local safeguarding authority when required.

People enjoyed the food provided. However, some improvements were needed to promote people's choice and mealtime experiences.

Improvements were needed to ensure that people's past lives, cultural and diverse needs were assessed and considered to enable individualised care that met all aspects of people's needs.

Some improvements were needed to ensure people were involved in the advance planning of their end of life wishes.

The provider had systems in place to assess, monitor and improve the quality of care. However, some of the systems were not always effective and improvements were needed to ensure areas of concern were identified and rectified.

Risks to people's health and wellbeing were managed and followed by staff who knew people well, which ensured people were supported safely.

The environment had been adapted in a way that promoted people's safety, independence and orientation.

There were enough suitability recruited and skilled staff to provide support to people. Staff had received training to ensure they had sufficient knowledge to carry out their role effectively.

People were protected from the risk of infection because the provider had policies and systems in place to control infection risks at the service.

Systems were in place to ensure that people received the least restrictive care and treatment to keep them safe and staff understood and followed the Mental Capacity Act 2005.

People were supported with their nutritional needs and action was taken to ensure people at high risk of malnutrition were supported effectively.

Advice was sought from health and social care professionals when people were unwell, which was followed by staff.

There were systems in place to ensure people received consistent care from staff within the service and also from staff from external agencies.

People received support from staff that were kind and compassionate. People's dignity was respected and their right to privacy upheld.

People were supported with their communication needs and information was provided in a format people understood which meant that people were supported to make informed choices.

People and their relatives knew how to complain. Complaints received had been investigated and responded to in line with the provider's policy.

People, relatives and staff felt able to approach the registered manager and the feedback gained from people about their care had been acted on.

The registered manager understood their responsibilities of their registration and worked in partnership with other agencies to make improvement to the way people received their care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Some improvements were needed to ensure that people consistently received their medicines as prescribed.

Staff were aware of their responsibilities to protect people from the risk of harm. However, some improvements were needed to ensure that all unexplained bruises were investigated and reported if required.

Staff knew people's risks and supported them to remain as independent as possible whilst protecting their safety. There were enough suitably recruited staff available to meet people's needs. Infection control measures were in place to protect people from potential infection risks.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed to ensure that people's diverse needs were considered in the assessment of their needs to enable effective planning of their care.

People enjoyed the food and were supported with their nutritional needs. However, some improvements were needed to ensure that there were effective ways to promote people's informed choices and mealtime experience.

People were supported to consent to their care and where systems were in place to ensure that decisions were made in people's best interests and in the least restrictive way.

People received support from staff who were sufficiently trained. People's health was monitored and health professionals input was sought where needed.

The environment had been adapted to promoted people's needs and independence.

Is the service caring?

Good

The service was caring.

People were supported to make choices in the way their care was provided. Staff understood people's individual ways of communication and information was provided in accessible formats.

Staff were caring and kind and showed patience and compassion when they supported people. Staff treated people with dignity and their right to privacy was upheld

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some improvements were needed to ensure that people's end of life needs were planned for in advance to ensure they were supported in line with their wishes.

Some improvements were needed to ensure people's cultural and diverse needs were considered to enable individualised care provision that met people's preferences.

People had the opportunity to participate in interests and hobbies that met their preferences.

People's care was reviewed and updated to ensure they received care that met their changing needs.

There was a complaints procedure available for people and their relatives to access if required and complaints received were acted on to make improvements.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

We found that the provider had systems in place to monitor and manage the service. However, some improvements were needed to ensure that all systems were effective in identifying concerns that needed rectifying.

Improvements were needed to ensure that staff followed the provider's equality, diversity and inclusion policy to provide care that had considered people's diverse needs.

Staff felt supported by the registered manager. However, some improvements were needed to ensure staff are informed about the changes made as a result of their feedback.

People, relatives and staff felt able to approach the registered manager. People and their relatives had been asked for feedback which had been acted on to make improvements.

The registered manager understood their responsibilities and worked in partnership with other agencies to make improvements to the way people received their care.

Abbeywell Court

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on Thursday 23 November 2017 and Friday 24 November 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had specific experience of care homes for people with dementia.

We used the information we held about the service to formulate our planning tool. This included information the provider sent us in the Provider Information Return. This 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. We also reviewed other information we held about the service. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, safeguarding concerns, serious injuries and deaths that had occurred at the service. We received information from local authority commissioners to gain their experiences of the service provided.

We spoke with five people and five relatives. We also spoke with four care staff, three senior care staff, three nurses, the deputy manager, the registered manager and the area manager. We also spoke to a visiting health professional to gain their views about the service.

We observed how staff supported people throughout the day and how staff interacted with people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We viewed seven records about people's care and eleven people's medicine records. We also viewed records that showed how the service was managed, which included quality assurance records, improvement plans and six staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when being supported by staff. One person said, "I feel safe they look after me well". Relatives we spoke with were happy with the way their relative was treated and felt assured that they were safe. We saw that people were happy and appeared comfortable when staff provided support. Staff explained their actions if they were concerned that a person was at risk of harm and the possible signs that people may display if they were unhappy and where abuse may be suspected. One member of staff said, "If I saw anything of concern I would report it to the registered manager immediately. I am confident that action would be taken by the management". We saw that the registered manager had referred incidents of suspected abuse to the local authority where there had been concerns identified. However, we found that some incidents of unexplained bruising had not been reported to the local authority. The registered manager told us that they had not reported these as some people are prone to bruising and they were not aware that this was a requirement. The registered manager told us that they would ensure that where bruising was unexplained they would report this as required. This meant that some improvements were needed to ensure people were protected from the risk of harm.

People told us that they were supported with their medicines. One person said, "The staff give it me on time and when I need it". We observed nurses administering medicines to people who used the service in a dignified and caring way. For example; we saw one nurse explained why it was important for the person to take their medicine and encouraged the person to take their medicine slowly. We found that the Medicine Administration Records (MARs) contained specific information about people's medicines such as frequency and dosage. We checked the MARs against the stock held at the service for eleven people to ensure they had received their medicines as prescribed. Most people's medicines balanced with the amount recorded on the MARs. However, we found that three people's medicines did not balance. The deputy manager and the nurse were unable to explain why these people had not received their medicines. This meant that we could not be assured that these people had received their medicines as prescribed.

We saw that protocols were in place for people's 'as required' medicines. We found that these protocols gave details of the amount of medicine required and why this medicine was required. However, we found that the protocols lacked details of how staff would recognise that people needed these medicines. For example; protocols did not always detail at what stage a person needed 'as required' medicine for their agitation or how a person who was unable to communicate displayed signs that they were in pain. Staff we spoke with had a good understanding of why and when people needed their 'as required' medicine. However, there was a potential risk that new or unfamiliar staff would not have this information. This meant that some improvements were needed to 'as required' protocols to ensure staff had sufficient information to support people safely.

We saw that people were supported with risks to their safety. People were supported to move carefully and safely by staff. We saw that people who needed assistance to move around the service had detailed manual handling plans in place which gave staff guidance on how they needed to support people safely, which we saw staff followed in practice. Risk assessments were in place to protect people from the risk of falls, skin damage, behaviour that may challenge and poor nutrition. For example; one person was at medium risk of

falls and had recently fallen. This information had been included in their plan of care and their risk assessment to ensure their risks were lowered and appropriate equipment was in place to alert staff when the person was mobilising. Staff we spoke with understood people's risks and knew how to protect people from harm in line with their plans of care. This meant people's risks were planned for and followed by staff to keep people safe from potential harm.

We saw records of incidents that had occurred at the service. These included the actions taken by the registered manager to lower the risk of further incidents. The registered manager had reviewed incidents and we saw that the required actions had been taken to lower the risks of further occurrences. For example, we saw that where people had suffered a number of falls or displayed a high number of incidents of showing aggression towards other people that used the service the registered manager had used the information within the incident records to gain further staffing for people to ensure their needs were fully met and people were protected from the risk of harm. We saw this had been effective as incidents for people had significantly reduced. This meant that the registered manager analysed incidents and took action to ensure people were safe from harm.

People and relatives told us there were enough staff available at the service. One person said, "Staff come straight away when I need them to help me". A relative said, "There are always enough staff about to help my relative". Another relative said, "I come to visit my relative most days and there are always staff about to help people". We saw people were supported by staff in a timely manner throughout the inspection. Staff we spoke with felt that there were enough staff available and plans were in place to cover shortfalls in staffing numbers. One member of staff said, "There are enough staff and if we have a shortage the manager uses agency staff. We have the same agency staff there is less disruption for people". The registered manager had a system in place to assess the staffing levels against the dependency needs of people. They told us and we saw that changes had been made to staffing levels when needed, which ensured there were enough staff available to keep people safe. This meant there were enough staff available to provide support to people and staffing was reviewed and changed to meet people's needs.
We saw that the provider had a recruitment policy in place and checks were carried out on staff before they provided support to people. These checks included references from previous employers and right to work permits. We also saw that criminal record checks had been undertaken which ensured staff employed were suitable to provide support to people who used the service.

People and relatives told us that the service ensured all areas were clean. One person said, "It is clean here. They [the staff] sweep up around here and mop it 3 times a day". A relative said, "The home is always clean and tidy. Any spills are cleaned up straight away". We saw that the environment and equipment were all clean and there was a cleaning schedule in place and we saw domestic staff regularly cleaning all areas of the service. The registered manager showed us how they assessed their infection control risks to ensure the prevention of infection and cross contamination. This meant people were supported in a clean environment and they were protected from the risk of infection and cross contamination.

Requires Improvement

Is the service effective?

Our findings

We found that before a person used the service an assessment of their needs was undertaken by the registered manager to ensure that the person's needs could met at the service. We saw that information was gathered from the person themselves, family members and any other representatives that were involved in the person's life. This information included details such as; the person's past medical history, physical and emotional needs and people's likes and dislikes. However, we found that the assessment form did not detail specific information about people's diverse needs such as cultural background and religion or their sexuality. We fed this back to the registered manager who stated that they would ensure that a care plan was implemented to include an assessment of people's diverse needs. This meant improvements were needed to ensure that people's diverse needs were assessed and planned for.

We observed lunch on the two days of the inspection and found that some improvements were needed to enhance people's choice and mealtime experience. People's choices were not always promoted. For example; we saw that people who were on a modified diet were not given the same choices as people who were able to eat unmodified diets. People on unmodified diets were given two choices of meal that met their preferences. However; we saw that people who required a modified diet such as easy chew or pureed were all provided with the same one plate of food. We asked the deputy manager and registered manager about this and they were unable to explain why people were not always given choices. We also found that some people who lived in the upstairs unit of the home experienced long periods of waiting for their meals to arrive. For example; people on modified diets were provided with their meals 30 minutes before other people who used the service. This caused some people to become anxious and agitated. One person repeated, "Why do we always have to wait. They [other people] always get theirs first. It's not fair. I'm going to go soon if it doesn't come". This person left the room and did not return and ate in their room because they did not want to wait any longer, which meant they did not enjoy the social aspect of the dining experience. The registered manager told us they would ensure improvements were made to the dining experience and promotion of people's choice. We will assess these improvements at out next inspection.

People told us they enjoyed the food at mealtimes. One person said, "The food is nice. We have fish and chips, chicken, ham. You get to say what meal you want, it's changed every day". Another person said, "I like the food". We saw plans were in place that detailed the individual support people needed to ensure their nutritional needs were met. For example, people who had been assessed as a high risk of malnutrition and had a support plan in place that detailed the actions required by staff. We saw that people who were at risk of malnutrition were encouraged to eat and assisted throughout mealtimes. Staff completed food and fluid intake charts to monitor the amount that people ate and drank which ensured people who were at risk were monitored and managed.

People and relatives told us they felt that staff were trained well. One relative said, "The staff are very good they are all well trained". Staff told us that they had received an induction when they commenced their employment, which included training to help them carry out their role. One staff member said, "We have received a lot of training in the past few months and it has really helped to refresh my mind. We are observed with manual handling by the trainer when we are unaware so that they can help us if we need

further training". We observed staff moving people safely in line with their training and staff were able to explain their responsibilities in various areas of care such as MCA and safeguarding vulnerable adults. Staff told us they had completed dementia training which helped them to support people effectively. The training records confirmed what staff had told us. This meant people were supported by suitably skilled and trained staff.

We saw that the environment had been adapted to help meet people's physical and mental health needs. This included bathroom equipment and grab rails in corridors. We saw that people were able to move freely around the service and the environment was clear of any hazards that could be a risk to people such as trips and falls. We also saw that the environment had been adapted to help people living with dementia. For example; people's private bedrooms contained names and photos of the person to aid people's orientation to independently access their own rooms. Communal rooms had signs in large print with a colour background which also helps people who suffer with dementia. We also saw that there was a large clock and activity programme in both lounges for people and a menu board in the dining area. This meant that the provider had considered people's needs and had made changes to the environment.

People who told us that they consented to their care and we saw that staff asked people's permission before they provided support. We observed staff asking one person if they would like to sit in a 'comfy' chair. The staff member waited for the person to respond and listened and acted on their responses. This ensured that this person had control of the support they received. This meant consent was gained from people to make decisions about their care and treatment.

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. Some people were unable to understand some decisions about their care and we checked that the provider was meeting their responsibilities under the Mental Capacity Act 2005. We saw mental capacity assessments had been carried out when people lacked capacity, which contained details of how staff needed to support people to make specific decisions in their best interests. Staff we spoke with understood their responsibilities under the MCA and explained how they supported people in their best interests.

We saw referrals had been made for Deprivation of Liberty Safeguards (DoLS), where people had restrictions in place to keep them safe. People can only be deprived of their liberty so that they can 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. Staff were aware of people's individual restrictions in place and we saw staff support people to keep them safe from harm in line with their individual DoLS. For example; one person had a condition in place on their DoLS which stated that their medicine needed to be reviewed monthly. We saw that this was being completed by the visiting G.P in line with the requirements of their DoLS. This meant that people were supported in the least restrictive way and in line with the MCA.

People told us they were able to see health professionals when they needed to. One person said, "I can see a doctor if I am unwell". A relative said, "They are very good at getting a doctor if my relative is unwell". We spoke with the visiting G.P who told us that they visited the service on a twice weekly basis. The G.P told us that the staff group was effective in identifying concerns that needed a G.P input and any advice provided was followed by staff. The G.P also told us about the Multi-Disciplinary Team meetings that were held at the

service every two weeks which was an opportunity for various professionals to discuss people's care as a group. The records we viewed showed that updates had been made to people's care as a result of these meetings. This meant that people were supported to access health professionals and systems were in place to ensure people's health needs were reviewed and updated in conjunction with external services.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring towards them. One person said, "I'm happy here. They [staff] are lovely to me". Relatives we spoke with also told us that staff showed compassion towards their relatives. One relative said, "The staff are very good there's one or two that have been made senior and you can see why. They are very caring". Another relative said, "The staff are very good here. They are caring and kind". Relative's told us that they were able to visit their relative at any time of the day and the staff always made them feel welcome. One relative said, "I come to visit nearly every day. I like to come and help my relative to eat and the staff are very good and help with this. It is important I am here for my relative as much as I can".

We observed staff interaction with people and found that staff were caring and compassionate when they provided support. For example; one person was supported to move and was anxious about being transferred with the equipment. We saw staff constantly providing reassurance and encouragement for the person. Staff took time and patience to ensure that this person was supported to move when they were ready and felt cared for by responding to their questions in a calm and caring way. We saw staff were given time to provide caring support for people in an unrushed manner and staff were able to sit and talk with people. Staff regularly asked people if they were okay, if they were warm enough or if they needed a blanket to put over their legs. This showed that staff treated people with care, kindness and compassion.

People told us that they were given choices in how and when their care was carried out. One person said, "They [the staff] give you what you want and if you don't like it they don't give it to you again". Another person said, "It's quite alright here because I choose what I want so I'm happy". We saw that people were given choices throughout the day by staff who were patient and listened to what people wanted. We heard staff asking people in a way that promoted their understanding and repeated questions if people hadn't heard or understood the question. People responded well to the way staff interacted and staff had a good understanding of people's physical ways of communicating their needs. For example; one person was unable to communicate effectively and we saw staff asking the person what they wanted. Staff were patient and gave the person possible answers to the question until the person responded by nodding their head in agreeance. Staff explained that another person used their eyes to communicate and if they were shown choices their eyes would change to alert staff of their choice. This meant people were supported to make choices in line with their individual needs.

We saw that large print information was available for people who had difficulty with their sight and we saw one person being supported by a member of staff to complete a word search which was in large print. We saw that information around the building such as toilet signs and the time and date were also in a large print to ensure everyone that used the service had the same information made available to them. This meant that the provider had ensured that information was accessible to all people who used the service.

People told us that they were treated with dignity and respect when they were being supported by staff. One person said, "Staff treat me well. I have no worries about the way they treat me". A relative said, "All of the staff are respectful towards my relative and everyone else here". Another relative said, "Staff treat my

relative with dignity. I would say something if I thought they were being treated in a disrespectful way". We saw that staff spoke with people in a way that respected their dignity, for example; staff were discreet when asking people what they needed help with. We observed a staff member supporting a resident with their drink, the staff member talked with the person and wiped their mouth at intervals to enable them to maintain their dignity. People were supported with personal care in privacy and were able to access private bedrooms and quite areas when they wanted some time alone. Staff we spoke with were aware of the importance of dignity and were able to explain how they supported people to feel dignified. This meant that people were treated with dignity and their right to privacy was upheld.

Requires Improvement

Is the service responsive?

Our findings

We found that some improvements were needed to the advanced planning to include people's end of life preferences and wishes. We saw that information was available regarding people's decision for a 'Do Not Resuscitation' (DNAR) order to be in place. A DNAR is a document issued and signed by a doctor, which informs a person's medical team that they do not wish to be resuscitated. We found that there had been no information gained from the person or their relative's that stated specific wishes and preferences such as; family contact, environment (for example; specific music, low lighting) and the person's wishes after their life has ended such as burial or cremation and whether the person had chosen a certain funeral director to look after these arrangements. The visiting G.P we spoke with had identified that this was an area that the service needed support with and was in the process of working with staff to think about how they need include this information in people's care planning. This meant that improvements were needed to ensure that information regarding people's wishes at the end of their life was available.

People and relatives told us and care records showed that they were involved in the assessment and planning of their care. One person said, "I am involved. My family come and sit in too sometimes [a review meeting]". One relative said, "I have always been involved with the care. I am confident that the staff know my relative well and knows what they like/dislike". We saw care plans contained individualised accounts of the person's care needs and how staff needed to provide support in a way that suited the person. However, we found that people's diverse needs were not always being assessed before they started to use the service and this important information was not available to staff. For example; people's cultural and religious preferences had not been taken into account to ensure that this part of their life was maintained. Details such as; types of religions and whether the person practiced their religions were not available. One person told us that they used to enjoy going to church regularly and they used to see a vicar at the service but this had not been made available to them for some time, which meant they had not been supported in this important area of their life. We also found that other diverse needs such as sexuality had not been considered at the assessment stage and people's sexual orientation were not detailed in the care records. This meant that there was a risk that people were not receiving a fully personalised service because all aspects of their life had not been considered.

People told us that they participated in activities within the service. One person said, "I do word search, magazines and gardening. I enjoy being involved". Another person told us how they loved to dance and sing. We saw that staff embraced this person's preference and the person was seen enjoying singing and dancing throughout the inspection. This person was happy and it was clear that they were enjoying themselves. Staff complimented the person on their singing and dancing skills which made them smile. We observed care staff spending time with people and supporting people with activities such as board games, word searches and having chats about childhood memories using a memories book to aid discussions. We also saw that the dedicated activity member of staff supported people with a game of dominos, interacting with people in a way that met their needs and providing praise when a person had a good turn. People appeared happy and settled and we did not observe behaviours that challenged through boredom. We saw that various activities were planned and detailed on an activity board in each lounge for people's information. This included, day trips out, external entertainment, reminiscence sessions, quizzes and board games. This

meant people were supported to access a variety of interests and hobbies that met people's preferences.

People's care was regularly reviewed and relatives told us that they were kept up to date with any changes in their relative's care needs. The records we viewed showed that monthly reviews were undertaken and people's care was reviewed after there had been an incident/accident. We saw that risk assessments and care plans had been updated to include specific guidance for staff to follow to keep people safe. This meant that people's care needs were regularly reviewed to take account of their changing needs.

People and their relatives told us they knew how to complain if they needed to and if they had complained the registered manager had acted upon their concerns to make improvements. One person said, "I'd tell a nurse and they would sort it for me". Another person said, "Yes, I would speak to a member of care staff. I have no complaints I'm happy with everything". A relative said, "I have no complaints, the majority of staff here are very good. If I had a complaint I would go to the office and speak to the manager". We saw that the provider had a complaints policy in place, which was available in an easy to read format and we saw that the registered manager had implemented a system to log any complaints received. We saw that complaints received had been acted on in accordance with the provider's policy. This included the actions taken to make improvements where required. This meant that complaints received were acted on to make improvements to the way people received their care.

Requires Improvement

Is the service well-led?

Our findings

We saw that systems were in place to monitor the quality of the service and to mitigate risks to people. However, some of the systems in place were not always effective. Care plan audits that had been carried out had not identified that records were not always up to date. For example; one person displayed behaviour that challenged and staff we spoke with knew how to manage this person's behaviours. However, there were no details in their plan to give new or agency staff information to ensure these risks were managed safely. Another person's care plan stated that they were fully mobile. However, this person needed hoisting to move as their needs had changed. Staff knew this person well and all staff gave consistent accounts but there was a risk that new or agency staff would not know this important information from their records. We saw that a staff survey that had been carried out contained actions to be put in place, However, staff were not aware of the actions taken to make improvements due to their feedback. There was no system in place to ensure staff knew that their feedback was valued and acted on. The registered manager told us the actions taken and agreed that it was important that staff knew what action they had taken in response to their feedback. The registered manager told us that they would ensure this was rectified. This showed that some improvements were needed to ensure that all systems in place to monitor the service were effective in identifying concerns.

We spoke with the registered manager about equality and diversity and how they ensured care was provided in line with the Equality Act 2010. The registered manager had some knowledge of the Act and was able to explain how they needed to support people who may have diverse needs. However, we saw that people's diverse needs were not always assessed and planned for. We saw that the provider had an equality, diversity and inclusion policy in place, which stated that care provided would meet people's diverse needs, but this had not been followed to ensure that people's diverse needs were assessed in all aspects of their life. This meant that although the provider had a policy in place to ensure equality and diversity was considered this was not always followed in practice.

People and their relative's told us that the manager was approachable. One relative said, "The manager is approachable. I saw them today. They seem very friendly and willing to listen to any concerns". Another relative said, "The manager is very nice, they have improved a lot of things since coming in. I had an issue a few months ago and the manager sorted it. I think they are very good for the home. It's clean and the care is very good. I like it because the manager deals with issues. The deputy manager is good and is here at week-ends too. I would recommend this home to anybody".

We saw that there was a residents/relatives meeting held at the home and people and their relative's told us they were asked for feedback on the quality of the care received. One person said, "Every so often I sign to say I am happy with the service. It comes periodically and any complaints I have they change things there and then". A relative said, "I'm going to a meeting on Sunday. I get asked my opinion and they have done everything they have said they would. For instance; I asked if my relative could go out and they have done this, which they really enjoyed". We saw that people and their relatives had completed a survey about the care received. The results of this survey had been analysed by the registered manager and actions taken required. For example; an action was to ensure the activity co-ordinator planned activities based on

people's preferences. People and relatives told us and we saw that people were supported to be involved in interests that were important to them. This meant that feedback was gained from people and their relatives to inform service delivery.

Staff told us the registered manager was supportive and approachable. One member of staff said, "The registered manager is always around and is supportive. We have a team approach, we work together and I feel valued". Another member of staff said, "The managers are all approachable and I can share ideas. The managers are responsive and listen to me". Staff told us and we saw that there were staff meetings to discuss all areas of practice and any updates in care. Staff we spoke with told us these were useful and helped them to keep up with any changes in care practice. Staff told us they received formal supervision with the registered manager on a regular basis. Supervision is a session for staff to discuss their practice and other issues such as their development needs. This meant that staff were supported to carry out their role effectively by a registered manager who was approachable.

We saw that the registered manager had regular contact with other agencies. This included health professionals such as G.P's, hospital staff and consultants. We spoke with the visiting G.P who told us that they had good relationships with the registered manager and staff which enabled them to ensure people's health needs were met in a timely way and that there was a holistic approach to people's care. We also saw that multi-disciplinary team meetings were held on a twice monthly basis to discuss people's needs with other professionals to ensure that all areas of their needs were discussed and assessed where needed. We saw that the registered manager regularly contacted commissioners to arrange for people's needs to be reviewed. This had ensured that people were provided with the staffing levels needed to meet their changing needs and to keep people safe from the risk of harm. This meant that the registered manager worked in partnership with agencies to make improvements to people's care and to ensure that people received appropriate care to meet their needs.

The registered manager understood their responsibilities of their registration with us (CQC). We saw that the rating of the last inspection was on display in the home for people and relative's to read. We had received notifications of incidents that had occurred at the service, which is required by law. These may include incidents such as alleged abuse and serious injuries.