Sense

SENSE - 1 Ashley Green

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

SENSE - 1 Ashley Green is registered to provide care and accommodation for up to five people who require nursing or personal care. The service specialises in providing care and support to people over the age of 18 with Learning disabilities or autistic spectrum disorder, physical disability and sensory impairment. The home is situated in a cul-de-sac and has an outdoor sensory garden area that included a sensory building, adapted to provide stimulation to people in the winter time when the weather was unsuitable to use the garden area. Off street parking was available with good access to the home.

The home was previously inspected on 16 March 2015 and was rated as Good in all domains except Safe which required improvement. This inspection took place on 24 May 2017 and was unannounced. The inspection was completed by one adult social care inspector and an expert-by-experience. At the time of our inspection five people lived at the home.

During our previous inspection in March 2015, we found that systems and processes in place to ensure people's medicines were managed and administered safely were not always effective and audits failed to highlight any areas that required improvement. During this inspection in May 2017 we found the registered provider had implemented improvements, which meant people received their medicines safely and these were managed according to the latest best practice guidance. Effective internal and external medicine audits had been completed that maintained the level of medicines management.

During our previous inspection in March 2015 we saw good evidence that risk was well managed. However, where records were required to evaluate any support provided for its effectiveness in providing people with improvements to their health, these records were not always robustly completed. During this inspection in May 2017, we found care plans included detailed risk assessments. Where people were at risk with their health for example, from malnutrition, detailed records included charts that recorded people's weight and these were reviewed to ensure they were effective and recorded the person's progress.
At the time of our inspection there was a registered manager in post. 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.

Procedures were in place which helped to ensure people were supported by care workers who understood the importance of protecting them from avoidable harm and abuse. Care workers had received training on how to identify abuse and report any concerns to the appropriate authorities.

There were sufficient care workers with appropriate skills and knowledge to meet people's individual needs and the registered provider had a robust recruitment process that ensured only care workers deemed suitable to work with vulnerable people had been employed.

People were supported to have maximum choice and control of their lives and care workers supported them

in the least restrictive way possible; the policies and systems in the service support this practice.

Care workers clearly understood and had developed a variety of resources that helped people to communicate their preferences and choices and we saw these were upheld and responded to throughout our inspection.

People and their relatives or advocates had involvement in their care planning. Records included how consent to care and support had been agreed and who was involved. This information was reviewed annually or as people's needs changed.

People were provided with a wholesome and nutritionally balanced diet which was of their choosing and care workers were proactive in supporting people to assist them with preparation and choosing their drinks and foods.

People were supported to access other healthcare professionals where this was required.

Care workers had a good understanding of people's needs and were kind and caring. They understood the importance of respecting people's dignity and upholding their right to privacy.

People were supported to undertake activities of their choice and these included holidays, and involvement with the local and wider community.

Systems and processes were in place to encourage, manage and investigate any complaints.

People who used the service, and those who had an interest in their welfare and wellbeing, were asked for their views about how the service was run.

Regular audits and quality assurance checks were carried out to ensure the service was safe and well run.

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 received their medicines safely and in a timely manner following best practice guidance.

There were sufficient numbers of skilled care workers employed that ensured people received the service that had been agreed with them.

Care workers received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse to the relevant people.

Risk management plans were in place and effective record keeping enabled people to receive safe care and support without undue restrictions.

Is the service effective?

Good

The service was effective.

Care workers received induction, support and training to ensure they had the appropriate skills to undertake their role and provide care and support that was tailored to people's individual needs.

People were supported to eat and drink and had access to other health professionals to ensure their health needs were supported.

The manager and care workers understood their responsibilities in respect of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

The feedback we received and our observations confirmed that care workers cared about the people they were supporting.

People's individual care and support needs were understood by

care workers, and people were encouraged to be as independent as possible.

People's privacy and dignity was upheld and respected by care workers.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care and support and care plans recorded information about their individual needs and their preferences.

The registered provider sought the views of close family and those directly involved with people including advocacy support services, to ensure care and support was accurate and reflective of people's needs, choices and preferences.

There was a complaints procedure in place and it was clear how any complaints would be investigated and responded to.

People were supported with their activities of their choice and information was available to enable them to communicate those preferences.

Is the service well-led?

Good

The service was well led.

Quality assurance systems, processes and audits were in place that helped to maintain and improve standards of the service.

Everybody spoke highly of the registered and deputy manager and the organisation and care workers understood their roles and responsibilities.

The registered provider sought the views of people and their relatives, who had responded they were happy with the service they received.

There was a variety of methods in place to share information concerning the service with people and staff within the organisation.

SENSE - 1 Ashley Green

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

This inspection took place on 24 May 2017 and was unannounced. The inspection was completed by one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance, their area of practice was learning disability services.

Prior to this inspection, we consulted with local authority commissioning and safeguarding teams and we looked at information we held about the service. This included notifications and a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection there were five people living at the home. We spent time observing interactions between care workers and people who used the service. We observed how people were cared for and supported and how they communicated their wishes and preferences. We observed how care workers responded to people where they were unable to verbally communicate with us and how they were supported during meal times. After the inspection we spoke with a relative of a person who received a service at the home.

We looked at areas of the home including some people's bedrooms and communal rooms. We spent time looking at documents and records that related to people's care and the management of the home. We looked at three people's support plans. We spoke with two full time care workers, two agency care workers and the deputy manager and inspected employee files that included training and supervision records for three care workers.

Good

Is the service safe?

Our findings

During our previous inspection we found that, although there were appropriate arrangements for the safe handling of medicines there was not always information available for care workers to follow to enable them to support people with their medicines correctly and consistently. Regular audits to check medicines were being administered safely were not being completed.

During this inspection we checked and found the registered provider had implemented improvements. The deputy manager told us, "Agency care workers do not administer medication at Ashley Green; they always work alongside a permanent care worker who has completed our medication eLearning and been competency checked by the service manager or deputy." Records confirmed care workers received training in medicines management and the registered manager showed us documented observations carried out annually as a minimum, which ensured they were competent in this task. Systems were in place to ensure medicines were ordered, stored and administered safely in line with the medicines policy and procedure. Suitable arrangements were in place for the storage of specific medicines that required cooler temperatures and checks were carried out on a daily basis to ensure medicines guidance was adhered to.

We observed medicines being administered and saw people who used the service received them as prescribed. Medicines Administration Records (MARs) were used to record when people had taken their prescribed medicines. The MARs we saw had been completed accurately. A six monthly 'management of medication' compliance audit had been completed by the registered provider and this, along with a recent pharmacy inspection ensured systems and processes were maintained and reviewed for their effectiveness. We found the improvements implemented meant people received their medicines safely and medicines were managed according to the latest best practice guidance.

During our previous inspection we saw good evidence that risk was well managed. However, we also saw that some aspects were not being managed as well as others. Where people were at risk of malnutrition, other professionals had been consulted to make sure they were receiving appropriate support. However, we saw records were not consistently maintained or reviewed to evaluate the individual's progress. During this inspection we found care plans included detailed risk assessments. Where people were at risk from malnutrition detailed records included risk assessments, associated support plans, contacts with other relevant health professionals and charts recording the persons weight. We saw these were regularly completed and reviews were documented that ensured they were effective and recorded the person's progress.

People were supported to live their lives as they choose and we saw risk assessments were in place which supported this approach with minimal restrictions in place. Care plans we looked at included comprehensive assessments associated with people's care and support and, where risks had been identified, these were recorded with associated support plans that helped to keep people safe. We saw risk assessments were in place for slips, trips and falls, travelling in a vehicle, using a kettle, eating and drinking, access to cleaning materials, health, finance, medication, choking, activities and personal care. Risk assessments covered areas of daily life which the person may need support with, for example, personal

hygiene, mobility, seizures and behaviours which may challenge the service or place the person and others at risk. These were detailed and provided care workers with guidance in how to mitigate the risks and keep people and themselves safe. We saw the risk assessments were reviewed for their effectiveness and where appropriate included input and guidance from other health professionals.

Other assessments for the home and environment had been completed. This helped to ensure equipment, maintenance and checks on utilities were completed in a timely manner to ensure everybody's safety.

We observed some external areas of the home that required attention including removal of some garden waste. We discussed these concerns with the deputy manager. They told us they employed a gardener, who we saw during our inspection. They said, "The gardener is due back at the weekend, the outside is their responsibility and we will ensure they complete the tasks identified at their next visit." They continued, "We are hoping to further develop the garden area to introduce more sensory plants for people to enjoy." The home had in place personal emergency evacuation plans for each person living at the home. These identified how to support people to move and evacuate the property in the event of an emergency.

People who lived at the home were supported by care workers who had completed training in safeguarding adults from harm and abuse. A care worker told us, "If I had any concerns about peoples welfare I would speak to the manager and if I had concerns about any bad practice I would report them using the whistleblowing procedure; it is important people are kept safe from harm, we are their eyes and ears." Another care worker said, "We have regular safeguarding training; it's a key part of our role." The registered provider showed us an up to date policy and procedure that was available both electronically and as a printed copy for further guidance. At the time of our inspection there had not been any safeguarding concerns at the home. The deputy manager confirmed their understanding of what constituted abuse and when to escalate any concerns to the local authority for further investigation. They showed us how safeguarding concerns would be recorded electronically. These records were escalated to senior management for further evaluation and learning to mitigate re-occurrence.

Care workers told us they had no concerns about any individuals who were involved with providing safe care and treatment. A care worker said, "We have a great team; we have the needs of people who live here at the heart of everything we do". This meant systems and processes were in place that helped to keep people safe from avoidable harm and abuse and that care workers were aware of their responsibilities and how to report their concerns.

We looked at staff rotas which confirmed there were sufficient care workers on duty at the time of our inspection. However, we were concerned that two out of the three care workers on duty at the time of our inspection were agency care workers and we discussed this with the deputy manager. They told us, "We have just lost some permanent employees and we have to rely on agency care workers at the moment whilst the new care workers complete the recruitment process." They continued, "We only use agency care workers as a last resort as we need to ensure consistent care and support for people; the ones we have at the moment are regular to the home and they know people and the people know them." Further checks and our observations confirmed this which meant people received consistent care and support.

We saw recruitment processes ensured people were not exposed to care workers who had been barred from working with vulnerable adults and helped to ensure that only care workers deemed suitable were employed. This included checks with the Disclosure and Barring Service (DBS) and a minimum of two reference requests completed with previous employers before care workers commenced their role.

The home was clean and tidy and free from any unpleasant odours. The home had infection control policies

and procedures in place and care workers had access to and used personal protective equipment, such as gloves aprons and hand soap to reduce the risks associated with infection. An annual infection prevention and control statement was available that was signed by the registered manager and included summary of related outbreaks of infection, audits, training and risk assessments. At the time of our inspection this was up to date with no outbreaks of infections recorded.

Systems and processes were in place to record, evaluate and learn from accidents and incidents. The registered provider told us on the PIR, 'Accidents and Incidents are logged on an online system and a hard copy kept on site; these are reviewed by the quality and health and safety teams.' The deputy manager showed us the system and we saw all records had been evaluated centrally by the quality team. Any near-miss incidents had also been recorded and evaluated to help prevent re-occurrence and to keep people to remain safe from avoidable harm.

Good

Is the service effective?

Our findings

It was clear from our observations with people and from talking with care workers that they were skilled in their role and understood people's needs. A relative told us, "Whenever I visit the home, there always seems to be enough care workers on duty; they all seem well trained and I have never worried about [name] safety in all the time they have lived there." A care worker told us, "I have worked here for a long time; most of us had up until recently, when some care workers left." They continued, "We have some agency at the moment, they are regular but anybody new is not left with anybody until they have completed an induction and until we are happy they are competent in their role and with supporting people." An agency care worker told us, "There is always at least one permanent care worker on duty, and usually a manager they are responsible for all the medication and support us with everything we do."

The registered provider told us on the PIR, 'New team members complete the care certificate, mandatory training (including equality and diversity, safeguarding) additional training to meet person's needs, shadow shifts are undertaken before supporting individuals.' Care workers confirmed and we saw from their records they completed an induction and a period of shadowing existing care workers before they commenced independent duties with people. New care workers had completed the Care Certificate. The Care Certificate' is a set of basic but fundamental standards for social care and health workers to adhere to in order to provide safe and compassionate care. A care worker told us, "There is a lot of training available, not just the regular training like safeguarding and medication but also other training to meet people's individual needs." Training records confirmed care workers had received generic training on topics such as fire, health and safety, first aid, moving and handling, medication, positive behaviour support (MAPPA) and safeguarding. We saw where a person required specific areas of individual support, for example with malnutrition and assistance with eating; care workers had received associated training that ensured they had the required skills to support people.

Care workers had a performance plan that was used to record how they were supported with their role and any development needs. This included documented one to one supervisions with their manager and observed practice supervisions to check their competencies in a variety of tasks. The deputy manager told us, "Competency checks are carried out by the service manager/deputy and began in January of this year, they are an alternative to repeated e-learning for some areas but we are still able to ask care workers to complete training if this is considered more appropriate for the individual." A care worker told us and we saw from records they received regular checks on their competencies that ensured they were competent in their role and identified any areas where they could improve their practice. These included everyday tasks for example, moving and handling, health and safety, infection control, food hygiene, communication, personal care, team work, medication and documentation. This meant care workers were supported in their role and received regular supervision and an annual appraisal.

We saw, where agency workers were used that the registered provider had a contract in place with their preferred agency to provide suitably qualified care workers. Along with the contract the deputy manager told us, "We use the same agency care workers and they all complete an induction, shadowing and have their competencies checked before working alone with people; they do not assist people with their

medication but do have to have an awareness around this activity." Records we looked at confirmed these checks and training were completed for agency workers. This ensured permanent care workers and those supplied from agencies were supported in their role and had the appropriate skills and knowledge to provide people with safe care and support.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked and found the service was working within the principles of the MCA. Where people had been assessed as lacking capacity under the MCA, DoLS applications had been completed and were in place. Where these had expired we found applications had been made to the supervisory body by the registered manager who was awaiting the outcome of these. Care workers had received training in the MCA and understood the importance of the act on their everyday role. A care worker said, "Sometimes people are unable to make big decisions about their care and support for example, one person doesn't have the capacity to understand why they have their medication and what it is for but can choose what they want to do each day; there is a DoLS in place to support them with their medication and we ask them what they want to do."

Throughout the inspection we saw care workers discussing people's preferences and gaining people's consent where ever possible by asking them before care and support was provided. People's ability to provide consent was assessed and recorded in their care plan. Best interest meetings were held when people lacked the capacity to make informed decisions themselves. These were attended by a range of healthcare professionals and other relevant people who had an interest in the person's care and welfare.

Care workers had received training on how to support individuals with multi-sensory and communication needs. It was clear from our observations they knew and understood how to communicate with and understand people who lived at the home. Each person communicated in different ways. A care worker said, "We try a variety of approaches to ensure people can be understood and we have worked hard to meet each person's unique needs by being quite creative as we develop close working relationships." This included a 'total communication approach', for example, verbal communication, objects of reference, hand under hand, observations and unrecognised individual communication modes. The deputy manager told us, "There isn't a one-fit-for-all solution; it's about being creative to enable and support people's independence."

We saw people's care plans contained information about their medical needs and how care workers were to support the person to maintain a healthy lifestyle. Previous and current health issues were documented in people's care plans and healthcare professional were contacted when support was needed, for example, GP's and dieticians. People were supported to access their GP when required and regular reviews were undertaken and recorded to ensure people remained healthy.

People's dietary intake was closely monitored by care workers and healthy eating was promoted. Detailed individual diet and food information was available in people's care plans and on separate printed sheets in the kitchen. This provided clear information of the person's individual eating habits, people who needed to be carefully monitored and who could be given more independence. People could eat when they choose to and their preferences were recorded. We saw people could have their meals at the times they preferred, which were prepared by care workers. Information was recorded and care workers were aware of what utensils to use to promote independence. Guidance ensured care workers could support people with their preference of drink, the vessel and temperature and encourage personal choice. We observed people requesting drinks throughout the day and that they were supported as much or as little as they needed to be

to make their drink. Where people were identified as having problems with swallowing, pictorial information and guidance was available to ensure they were seated in the correct position and the best size of food pieces was recorded to reduce the risk of chocking.

Good

Is the service caring?

Our findings

We observed care workers and management were caring and compassionate towards people. No body appeared rushed and there was a homely atmosphere with care workers and people positively interacting around the home. A care worker said, "We try and respond to everybody's individual needs and requests, which results in people who are very well cared for." Another care worker said, "We are a very supportive team, including management, and we work together to provide people with the care and support they deserve, it can be challenging but the rewards of working with people with a variety of individual needs are why I work here."

The registered provider told us on the PIR, 'The staff team understands the importance of consistency, routine and to work at the individuals pace; care workers are made up of people from different backgrounds that bring a wealth of experience and are matched with individuals to share skills, giving companionship and enjoying their time together." We saw people who used the service and care workers had good, respectful relationships. Care workers were aware of people's needs and the support people required to lead a fulfilling life. There was lots of laughter and good humour around the home and it was clear people enjoyed the care workers and each other's company. Care workers told us how they had developed long-term working relationships with people and understood their needs and aspirations. A care worker said, "It is lovely here and I am very happy; people who live here are like family and have progressed so much in the time I have known them." Another care worker said, "Some people have quite complex needs, but once you get to know them you learn they have so much to offer and we support them to have as good a life as possible."

Care workers understood the importance of maintaining people's dignity and treating them respectfully. A care worker said, "We always make sure people are dressed with clean clothes as they prefer to be, and when it's time for their personal care we always make sure we have all the lotions and potions and dry warm towels; we close doors to ensure people have time on their own if they want to, as long as they are safe to do so." Another care worker told us, "I always make sure I have enough towels available to keep people covered up when I help them with bathing and personal care, I don't treat people any differently than I would wish to be treated in my own home."

We observed care workers knocking on doors and asking if it was alright for them to come in before entering people's private rooms and occupied toilets. Where people had hearing problems the light in their rooms was fitted to a switch that made it flash. Care workers pressed this switch to alert people they needed to enter their room, which helped people to avoid any surprises or embarrassing situations.

Care workers told us how they ensured people's confidentiality was maintained. A care worker said, "Anything that concerns a person is confidential to that individual and where agreed, with others directly involved in their care, it's not for discussion in the supermarket or with a neighbour."

People were supported with a key worker. The key worker had responsibility for the person's reviews and was the main point of contact. Keyworker meeting were completed every month and relatives confirmed

they were invited. A relative told us, "We are included in everything; we are invited to all [name] appointments and they [registered provider] inform us of anything they feel we should know." We found families had a key role in people's care and support. This was confirmed by the deputy manager who told us, "We support people to attend home visits to Doncaster and Sheffield and one individual is taken to Castleford every other weekend to stay with their family."

Where people in the home did not have close relatives or independent support the registered provider had engaged an advocate to support them with day to day decisions. The advocate made sure people's rights were protected and ensured they received the services and support needed to live life to the full. Advocates can help people with independent support and advice and can speak on the person's behalf on a range of decisions, including the person's home, relationships, finances and health.

The deputy manager told us where people had a preference for a male or female care worker this was supported. This was confirmed on the PIR where the registered provider had recorded, 'We have been working to employ male care workers over the last twelve month to support an individual who we feel likes male company in our latest recruitment we offered two males full time positions and we are currently awaiting employment checks.'

Where people had been consulted on their wishes and preferences for end of life care and support and where they had agreed, this information was available and recorded in their care plans.

Good

Is the service responsive?

Our findings

The deputy manager and care workers advised the focus of the service, and what they were good at was providing the best possible care and support that was responsive to people's individual needs and preferences. A care worker told us, "We are a small team, we work well together and we provide a marvellous service for people." Another care worker said, "We encourage people to live the lives they choose, people can feed themselves; we support them, people know what they like to do and what they don't and we support them to be as independent as they can be." The deputy manager told us, "People make their wishes and preferences known and where required we offer them care and support to achieve their goals." A relative of a person said, "[Name] has come on leaps and bounds since living here in this setting, they can dress themselves, they can make drinks; they [care workers] really get [name] to do things we didn't think they could ever do."

The deputy manager told us, "We use various methods of communicating with people, each person has an object of reference, which is an object that the person can either see or touch that link to something they enjoy doing." They showed us objects that were available in people's rooms and in the corridor downstairs. They included a wooden spoon that meant the person wanted to bake, a paint brush to do some art work, plastic flowers that meant the person wanted to go out into the garden, a plastic fork that a person used if they wanted to go for a meal out and a wine bottle or beer mat for a visit to the local pub. These items could be found in the people's bedrooms and were duplicated in the corridor down stairs. Each of the items of reference were different to each person, this allowed for different kinds of understanding and also helped with continuity of communication between the person and their family.

Everybody living at the home had a care plan in place. Those we looked at were centred on the individual and provided holistic information and guidance that was reviewed and updated at least annually or when people's needs changed, for example, due to changes in health. A one page profile included a photo of the person and key information regarding their next of kin, allergies, health and associated contacts. Although people were unable to sign their agreement to the contents of the plans, a 'How was I involved in the plan?' recorded how records of observations of people's behaviours, vocalisations and body language whilst undertaking activities had been evaluated and used to help build the information. Family members or advocates had been involved in signing their agreement that contents of people's care plans were accurate.

Information recorded how to support people with their morning and evening routines was included in their care plans and provided detailed information on the amount and type of help required and how to communicate with the person. A morning routine recorded, 'Offer the person a choice of clothes, tops and trousers, the person will choose and will dress independently.' Our observations confirmed care workers were aware and encouraged these routines. Activities throughout the day were recorded for people. Guidance ensured care workers had the information to support people safely and to promote their independence to achieve documented outcomes that included, choice, to keep fit and to build on their confidence, to overcome any barriers, increase their interaction and confidence and widen and increase social interactions.

The home had a sensory garden with ball games, scented flowers and plants and a building developed for winter time where people could go for individual sensory experiences. The deputy manager told us, "The outside space is great, it is safe and secure and easily accessible for people whenever they choose to go outside."

Care workers interacted with people as much or as little as they wanted and the environment was representative of, and they were treated as, residents in their own home. People were able to get up and go to bed when they wanted to. We observed people could wander around to different rooms and go in and out of the garden if they choose, without excessive interventions or restrictions in place. One person enjoyed making their own drinks. We observed care workers helped the person to make a cup of coffee. The person was asked to choose the cup and drink and helped to open the lid of the coffee jar. The person knew to go and get the milk from the fridge. We observed a team effort that would have been much easier for the care worker to complete for the person. However, care workers were confident and risk enabled people to be as independent as possible... We saw this support gave the person a chance to do something for themselves and not have everything done for them. We found some people were partially sighted or blind. However, this did not stop care workers enabling them to have a go at things. This was a great example of positive risk enablement.

The registered provider had a complaints policy and procedure which was displayed around the home. This was also available in alternative formats to meet people's individual needs. At the time of our inspection no complaints had been recorded. The registered manager told us, "We get very few if any complaints, but if we did they would be investigated and responded to in line with our policy statement."

Care plans included a 'health passport'. This contained information regarding a person's medical and health support needs and provided information to other health professionals should the person need to attend or transfer between other health appointments.

Good

Is the service well-led?

Our findings

At the time of our inspection the registered manager was on holiday and we were supported by the deputy 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.

The deputy manager understood the responsibilities to ensure the CQC was informed of events that happened at the home which affected the people who received a service.

The atmosphere of the home was very relaxed and homely. Everybody we spoke with told us they found both the registered manager and the assistant manager open, honest and approachable. We found that management was clearly involved with every aspect of the service.

We observed people who received care and support were happy and approached the deputy manager and care workers as we moved about the home and they came to chat with them in their office throughout the day. We saw relationships in the home were all friendly and care workers acted as companions to the people who lived there.

Care workers told us how staff meetings kept them informed about any changes and provided them with an opportunity to discuss people's individual needs, what was working for people, what required improvement and any areas of concern they had. A care worker confirmed "We have regular staff meetings which are full of discussion and information on everything that is going on in the home." Minutes of the meetings confirmed information was recorded and discussed and included actions from previous meetings, people living at the home, policies and procedures, and areas of competency testing. A care worker said, "We are tested on our understanding and knowledge around our work; this can include fire safety, risk assessments and medication or first aid."

The registered provider showed us a folder that contained all changes to records of information about people and the home. All care workers were required to read and sign the information to ensure they were aware of and understood the changes documented. The deputy manager told us, "The file ensures everybody is aware of what is going on with people and any developments, once everybody has signed their understanding the information is transferred to the relevant file."

We were provided with a copy of a quarterly magazine that included further information to share 'great ideas, good practice and successes' across the home and the organisation. This included a dignity in action day to promote the treatment of individuals to ensure they were given choice, control and a sense of purpose over their daily lives. We found this also detailed fund raising events and global news of successes in other countries and recognition by Skills for Care of the of the support the organisation provided to the registered managers across its services. A care worker said, "I really wouldn't work anywhere else, we are very well supported and there is so much support and information available; it's a great organisation."

The registered provider sought the views of people who lived at the home and their relatives. The registered manager sent out annual questionnaires to each family member. We looked at the most recent survey that had been completed in March 2017. The survey encouraged feedback and input to help identify any areas where the service could be improved. We saw feedback was positive. For example, People confirmed they were aware how to make a complaint and all responses confirmed families were 'very pleased' with the care and support the relatives received from care workers and management."

The registered provider had systems and processes in place to review, evaluate and improve services. A quality folder included records of six monthly audits for the management of medication compliance, individual support and service management, finance compliance and training.