Domain Care Limited

Staley House Care Home

Inspection report

Huddersfield Road
Stalybridge
Cheshire
SK15 2PT

Tel: 01613048939
Website: www.staleyhouse.co.uk

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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

This inspection took place on the 24 and 26 April 2017 and was unannounced on day one of the inspection.

Staley House is situated in the Stalybridge area of Tameside Manchester. The home provides care, support and accommodation for up to 27 people who require personal care. All rooms provide single accommodation and 12 of the rooms have the facility for an en-suite toilet. Bedrooms are located over two floors and the first floor can be accessed using a passenger lift or staircase. The home also provides communal bathrooms and toilets. In addition to this there are two communal lounges, one of which has a separate quiet area. The rear lounge overlooks a patio and secure gardens with space for people to sit outside. The building is situated in its own grounds and has off road parking. At the time of our inspection 26 people were living at the home.

We previously inspected this service under a different registered provider. At this inspection a new provider was registered with the Care Quality Commission in March 2017.

A registered manager was in place. 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 saw positive and caring interactions between care workers and people who used the service and people were supported by sufficient numbers of care workers to make sure their health and wellbeing was promoted.

Arrangements were in place to help protect people from the risk of abuse. The service had an up- to-date safeguarding policy and procedure in place. Care workers spoken with were able to give a good account of the risks associated with vulnerable adults, the safeguards in place to minimise these risks and provided an explanation how they would recognise and report abuse.

We saw records to show care workers had received regular supervision or an annual appraisal to help make sure they were carrying out their duties safely and effectively.

Weekly cleaning audits were completed and up to date. However we saw some moving and handling equipment used to assist in transferring people required cleaning to maintain a good standard of cleanliness and help to prevent cross infection.

Care workers used the protective personal equipment (PPE) in place such as disposable aprons and gloves when delivering care to people. This meant people were protected against the risk of cross infection.

Auditing systems in place helped to monitor that the quality of services provided were fully utilised to make

sure the service provided was safe, effective and well led.

Care workers we spoke with told us they had undergone a thorough recruitment process. They told us following their employee induction, training appropriate to the work they carried out was available to them.

Peoples nutritional and hydration needs were being met. People had choice about what they wanted to eat and drink and where required they were supported to eat their meals with prompts from care workers.

Care workers had developed a good rapport and understanding of the people who used the service and treated the people and their belongings with respect.

People were supported to take part in hobbies and interests and individual or group daily leisure activities were provided for people.

A complaints policy was in place and copies of the policy were displayed in communal areas in the home. We examined the services complaints log and found where complaints or comments had been made records were kept of the actions taken to resolve the issue to the satisfaction of the complainant.

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.

Safeguarding policies and procedures were in place and care workers knew how to protect people from the risk of harm.

Employee recruitment processes in place helped to make sure new care workers were suitable to work with vulnerable adults.

Risks to people were identified and detailed in their care records. Written information showed care workers how to mitigate any risks to people.

Systems were in place to make sure medicines were administered safely by suitably trained care workers.

Is the service effective?

Good

The service was effective.

Care workers received an employment induction, regular supervision and training to help make sure people were provided with care and support that met their needs.

Where people were being deprived of their liberty the registered manager had taken the necessary action to make sure people's rights were considered and protected.

People had access to external healthcare professionals, such as hospital consultants, specialist nurses and General Practitioner's.

Is the service caring?

Good

The service was caring.

People received care and support from care workers who knew them well.

We observed positive interactions between care workers and people who used the service.

People's care records were stored securely to maintain

confidentiality.

Is the service responsive?

Good

The service was responsive. □

People's needs were assessed prior to them receiving a service. Care records identified risks to people's health and well-being.

People's health care reviews were held annually or more frequently if necessary. Specialist guidance was included in people's care records.

People told us they felt confident in raising concerns or complaints with the registered manager or care workers.

Is the service well-led?

Good

The service was well-led

The registered manager promoted a person centred approach to help make sure people's needs and preferences were met.

Systems were in place in order to monitor the quality of the service.

People's relatives and care workers spoke positively about the registered manager and the deputy manager.

Staley House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 24 and 26 April 2017 and the first day was unannounced. The inspection was carried out by one adult social care inspector.

Prior to this inspection the registered provider was not requested on this occasion to provide a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed information we held about the service. This included notifications the provider is required to send us in relation to safeguarding, serious injuries and other significant events that occur within the service. We reviewed previous inspection reports and any information shared with us about the service through our contact centre, by email or online using a 'share your experience' web form.

We sought feedback from the local authority quality assurance team and health protection nurse and the National Health Service (NHS) clinical commissioning group (CCG). We received positive feedback from the quality assurance team and CCG medicines management team. This information was reviewed and confirmed they had no current concerns about the home and the services they provided. We used the information received to help plan our inspection.

During our inspection we spoke with three people who used the service, the registered manager, the deputy manager and three care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing delivery of care to help us understand the experience of people who could not talk with us.

We looked at the care records that belonged to four people who used the service, four employee personnel files, records relating to how the service was being managed such as safety audits, records of training and supervision, records of maintenance and servicing of the premises and equipment and quality assurance.

Good

Is the service safe?

Our findings

When we spoke with a person who used the service they told us that they felt safe living at the home. A visiting relative said, "Yes, most definitely [person's name] is safe here". We saw systems to help protect people from the risk of abuse were in place. The service had a safeguarding policy and procedure which was in line with the local authority's 'safeguarding adults at risk multi-agency policy'. This provided guidance on identifying and responding to the signs and allegations of abuse. We looked at records that showed the registered manager had suitable procedures to help make sure any concerns about people's safety were appropriately reported. Care workers we spoke with were knowledgeable and confident about the services safeguarding procedures. They confirmed they had received safeguarding and whistleblowing training and shared their understanding of the service's whistleblowing policy (the reporting of unsafe and or poor practice by staff). They told us they would contact the registered manager or deputy manager to inform them about any concerns. Staff training records showed they had received training in both topic areas.

We examined the care records that belonged to four people who used the service these showed that risks to people's health and well-being had been identified. The registered manager had introduced a traffic light risk matrix to identify the level and impact of a risk associated to individual people where there were concerns. For example green indicated a low risk, amber, a medium risk and red indicated a high risk. Where risks were identified as amber or red, the registered manager or senior care workers would be alerted to contact a person's general practitioner (GP), health care professional or the emergency services. Environmental and equipment risk assessments had been completed for all people living in the home, for example when being assisted to mobilise via the use of a hoist. Risk management plans showed where there was a high risk to a person of falls and clearly showed the factors which might increase the likelihood of the risk occurring and the action care workers should take to reduce the risk. Care workers we spoke with understood their role in relation to people's identified risks and what to do should the risk occur.

An accident and incident policy and procedure was in place. Records of any accidents and incidents were recorded, analysed to check if there were any themes and had been reported appropriately to the Care Quality Commission and the local authority adult social care team. Records showed all of the people living at the home had a Personal Emergency Evacuation Plan (PEEP) in place. These plans detailed the level of support a person would require in an emergency situation such as a fire evacuation. We saw records to indicate that all staff had undertaken fire safety training at regular intervals.

When we examined the staff roster we saw that the ratio of care workers to people who used the service was maintained at a consistent level in order to safely meet the support and the dependency needs of people who used the service. A recruitment and selection procedure was in place. We looked at four employee personnel files and found that all of the staff had been recruited in line with the regulations including the completion of a disclosure and barring service (DBS) pre-employment check and at least two recent references from previous employers. Such checks help the registered manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults. All care workers and staff in different roles were issued with an employee handbook which contained information about the services policies, procedures and management expectations of staff. We spoke with three care workers, who

described their recruitment to the service. They told us that after completing an employee application form, they were invited to attend a face to face interview to assess their suitability for the job. Following a successful interview the registered provider carried out the necessary pre-employment checks which included proof of the employee's identification (ID) and two references, one being from a recent employer. When we examined a sample of care worker recruitment records we saw evidence that they were not assigned any work until the appropriate ID, references and clearance from the DBS had been received and found to be satisfactory.

We examined the systems in place to monitor the way medicines were being managed at the home and to ensure people received their medicines safely. We found medicines were kept safely and securely. We reviewed a sample of medicine administration records (MAR) and found they were completed appropriately and were up to date. We saw there was a photograph at the front of each person's records to assist staff in correctly identifying people to ensure they received the correct medication as prescribed by their general practitioner (GP). Senior care workers we spoke with knew the process for checking the right dose of medicines and that these were administered according to the person's GP instructions. They demonstrated a good knowledge of why people required their medicines, the dosage, the desired effect and the action they should take in the presentation of possible side effects. They told us that in the case of a medicines error they would seek immediate advice from the person's GP or the National Health Service (NHS) 111 service. This is the NHS non-emergency number where people can speak to a highly trained adviser or healthcare professionals to obtain any health or medical advice. We observed part of the morning medicines round being carried out which confirmed people's medicines were administered safely. The registered manager undertook monthly and weekly medicines audits to check that medicines were received, stored, recorded and administered safely. When we examined these audits we saw that they were properly completed and up to date. This meant people were protected from the risk associated with the unsafe management of medicines.

A person we spoke with told us that their medicines were given to them on time and this was confirmed by a visiting relative who said, "Always, when I visit I see [Person's name] taking their medicines around the same time. Actually [Person's name] has just told me they are waiting for their tablets to be given so they could take them with their breakfast".

During a tour of the building we saw that a new laundry system was in place. We saw that new laundry trolleys with lids had been purchased and were located on the ground floor and second floor of the home. Each laundry trolley contained three different coloured fabric laundry bags which represented a specific use. For example white laundry bags were used for non-soiled bedding, blue for non-infected personal items and heavily soiled clothing or bedding would be placed in a red alginate (soluble) bag and then placed inside the red laundry bag. We saw that the existing infection control policy was in place and risks in relation to the safe handling of laundry had been assessed and recorded. We saw that care workers and housekeeping staff had signed the laundry policy to demonstrate their understanding of the policy and knew what the potential risks were to people if the policy and practices were not followed. We saw records to demonstrate that this topic had been discussed in supervision sessions with individual members of the staff team.

Care workers we spoke with demonstrated a clear understanding of the laundry system and told us they found the laundry trolleys were useful in assisting them when carrying out their routine laundry tasks. We saw that the cellar rooms had been re-organised to accommodate a dirty laundry storage room, wet room and dry room. This meant there was a dirty to clean work flow system in place so that clean and fouled items were physically separated throughout the laundry process. We saw that dry foods which were previously stored in the cellar had been moved and were stored safely inside a newly created walk in pantry located next to the kitchen. This meant the risk of cross contamination to people and staff members was

minimised.
When we walked around the building we saw that all doors with signage informing that the doors to "keep locked shut" were closed or locked shut as instructed. All cleaning fluids and cleaning equipment were stored within a locked cupboard. We saw the building was clean and secured, however we saw that the home lacked investment regarding bedrooms and communal areas that required redecorating.

The registered manager was responsible for making sure health and safety audits were carried out on a regular basis and also, that regular checks on windows, doors, lighting and heating were completed. Records indicated that fire equipment checks and fire drills were carried out regularly. We examined records that showed regular checks had been undertaken for water temperature, electrical appliances and portable appliance testing. We examined records to show that environmental risk assessments had been undertaken using a system for documenting and recording any maintenance work required. Weekly cleaning audits were completed and up to date. However some moving and handling equipment used to assist in transferring people required cleaning to maintain a good standard of cleanliness and help to prevent cross infection.

Good

Is the service effective?

Our findings

When we spoke with a visiting relative they were complementary about the care workers and their ability to provide people with the care and support required. They said, "Most definitely staff know their job".

We saw records to show care workers were qualified in National Vocational training in Health and Social Care. The registered manager told us that induction training would be provided via the Care Certificate for new care workers. The Care Certificate is a national recognised qualification that aims to equip health and social care workers with the knowledge and skills they need to provide safe and compassionate care. We saw records to show the registered manager carried out medicine administration competency assessments. This meant that care workers designated to administer medicines were supported and monitored and had received training appropriate to their role. This helped to make sure people received safe and effective care.

The registered manager told us that training would be arranged for care workers where it was identified particular skills and knowledge would help to meet people's specific health and wellbeing needs. This was confirmed when we examined the staff learning and development plan. We saw that whilst care workers had undertaken training in dementia awareness, the registered manager had scheduled external training for eight care workers to undertake 'creative dementia' training. This training is geared towards assisting care workers in how to introduce specially designed activities for people with dementia. Care workers we spoke with said, We are up to date with our training" and "We have recently done refresher training in infection control, medication and moving and handling".

We saw there was an ongoing annual staff appraisal and supervision system in place. The system was used at regular intervals to discuss and evaluate the quality of care worker's individual performance and where best practice was in place. Care workers we spoke with confirmed they received supervision at least every four months and an annual appraisal. We examined four care workers supervision records which showed that individual supervision sessions had taken place and future dates were planned. Staff supervision provides the worker with the opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. They told us they had undertaken a full mandatory induction that covered topics such as fire evacuation, safeguarding, food hygiene and infection control. This induction was followed by a two week period of shadowing (working under the supervision of an experienced care worker) within the home. This gave the new care worker the opportunity to get to know the people who used the service. A probationary period of 12 months was in place to support the care worker to develop additional skills to meet their job role expectations.

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

service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us that DoLS applications were required, and had been submitted for some people living at the home. We saw a tracker was in place to monitor when applications had been made to the supervisory body (the local authority) and when any applications had been authorised. The registered manager and care workers were knowledgeable about the MCA and the need to carry out mental capacity assessments for people who required them. A care worker we spoke with said, "DoLS is where people can't make decisions for themselves. We monitor people and inform the manager if we think people might need a mental capacity assessment".

The service supported people with varying levels of support needs ranging from people being able to mobilise around the home unsupported to people who required support to mobilise using mobility aids or general assistance from care workers. Care workers we spoke with had a good understanding of how and why consent must be sought to make decisions about specific aspects of people's care and support. We observed care workers carrying out support interventions such as mobilising people in wheelchairs around the home. A care worker we spoke with confirmed their approach was to always seek a person's consent before providing care to a person. They said, "We have to ask people what they want us to do for them. If they can't tell us, then we always explain to them what care is going to be given to remind them of their routine". The registered manager told us that where consent from people could not be sought they would always approach the person's relative or arrange for a meeting to be held with appropriate professionals in attendance. A visiting relative said, "We are informed all the time about the care provided to [Person's name]. We are happy with the care that is given".

We saw the meals served were well presented, looked appetising and nutritionally balanced. We saw people had choices about what they wanted to eat and where required they were assisted or supported to eat their meals with prompts from care workers. Dining tables were set for each meal time and where people preferred to eat in their rooms they were supported to do so. We saw people were offered a variety of drinks to maintain their hydration and snacks throughout the day. We examined the menu and saw that a variety of meal options were available at different times of the day. Care records and daily records we examined showed attention was paid to people's dietary requirements and what they ate and drank. We examined people's daily observation and weights records which indicated the type and amount of food people had eaten. This meant people's nutrition and hydration was monitored to ensure their nutritional needs were being met. When we spoke with a cook it was apparent they were knowledgeable about people's dietary and nutritional risks. They were aware of the need to follow the speech and language therapist (SALT) instructions. For example making sure that people at risk of choking received a pureed diet. SALT provides treatment support and care for people who have difficulties with communication or with eating, drinking and swallowing. A person we spoke with told us that they enjoyed the meals served and said, "The food is very nice; I enjoy it".

Care records we examined showed people had access to external healthcare professionals, such as hospital consultants, specialist nurses and general practitioners (GP's). Notes of such visits were included in people's care plans. Other care records showed attention was paid to people's general physical and mental well-being, including risk assessments. For example where people were at risk of developing pressure sores this had been identified and recorded and appropriate health care support, such as a district nurse, was requested. Care records that recorded people's weight, dental and optical checks were also in place and reflected the care being provided to people.

When we walked around the home we saw areas of the home, such as the main corridor, lounge and dining

room were planned in such a way to be helpful to people living with dementia. Most of the shared toilets, showers, bathrooms and lounge areas had clear signage which assisted people living with dementia to navigate around the home safely. However some door signs had been removed by people who used the service and the registered manager was in the process of sourcing more robust signage at the time of the inspection.

We saw there was sufficient and suitable equipment in place to promote people's mobility such as handrails and wheelchairs. Appropriate raised seating was provided and pressure relieving cushions were well maintained and in good condition. Corridors were wide enough for wheelchairs and other mobility aids to manoeuvre adequately. The service maintained a homely environment to enable people's planned activities and routines to be supported effectively by care workers.

Good

Is the service caring?

Our findings

People who use the service told us they were happy living at Staley House and felt they were receiving good care and support from the care workers. We saw that care workers had developed a good rapport and understanding of the people who used the service and treated the people and their belongings with respect. It was apparent from interpersonal relationships and interactions we observed between care workers and people who used the service that care workers understood people's different communication styles, for example where people who did not use words to communicate we saw care workers remained patient and addressed them in a respectful way which helped promote their dignity. We saw staff showing warmth, kindness and empathy towards people who preferred to walk around the home. One person liked to visit the main office and arrange paper work as though they were working in their previous job. At no time did the manager or care workers obstruct the person to prevent them from accessing to the office. The registered manager said, "This is their home; they're not a problem. Sometimes they just like to sit in here with us and have a cup of tea. It's no trouble to us. As long as they are safe and happy, that's all that matters". We saw care workers shared friendly conversation, smiling and laughing with people whilst gently escorting them to their chosen destination such as the lounge.

From our observations and examining peoples care records we saw that people were encouraged to remain as independent as possible. We saw care workers supported people to manage tasks such as eating/drinking and mobilising around the home within their capabilities. Care records examined were detailed, contained clear information about people's needs and had been written with empathy and understanding. Throughout our inspection we observed and saw evidence within people's care records that there was a culture of promoting and maintaining people's independence wherever this was possible. When we spoke with staff about people's identified needs they were able to demonstrate they knew people very well and gave examples of how people preferred their care and support to be given. We saw these details had been accurately reflected in people's care plans which showed the staff had a good understanding of providing individualised care.

Care workers were respectful of people's wishes, knocking on bedroom doors before entering and using people's preferred names when speaking with them. It was apparent that respect and regard for the rights and dignity of people who used the service were central to the delivery of care and support and geared to people's needs.

The registered manager told us the service was able to link in with a local advocacy service to ensure that people who did not have any relatives living nearby had someone they could turn to for advice and support when needed. An advocate is a person who represents people independently of any government body. They are able to assist people in ways such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them. People's care records showed that where it was not possible for them to be involved in decisions about their care, their relatives had a Lasting Power of Attorney (LPA). LPA is a legal document that lets the person appoint one or more people (attorneys) to help make decisions on their behalf. Types of LPA can relate to health, welfare, property and financial affairs.

We saw that all records and documents were kept securely in locked filing cabinets accessible only by designated key holders and no personal information was on display. This ensured that confidentiality of information was maintained.

The registered provider had implemented the 'Six Steps' model of end of life (EoL) care at the home. This model of care helped to support staff in the delivery of end of life care to people. Whilst we saw training records to show that only eight out of 23 care workers had received training in end of life care. The registered manager told us they had already contacted the local authority end of life coordinator who told them they would be providing further staff training in this topic when more training dates and training places became available this year.

We looked at the home's end of life care policy and procedure which was person centred and geared towards helping the person, and their relatives to have as full control about decisions relating to the person's future care and end of life needs. The registered manager told us that relevant specialist health care professionals and nurses would always be available to ensure people had experienced personalised, compassionate and dignified care at the end of their lives.

Good

Is the service responsive?

Our findings

When we examined the care records of four people who lived at the home we saw that a comprehensive needs assessments had been undertaken before people began to use the service. These assessments had been completed to make sure the home had the appropriate equipment and care workers to meet peoples identified needs. Consideration of social, communication, mobility skills and interactions was recorded along with people's physical and mental health needs. People's individual care records contained sufficient detail to guide care workers on the care and support to be provided such as emergency contact details, next of kin, and General Practitioner (GP). Risk assessments, current support needs, the support to be provided and the desired outcome from the care and support provided were also in place.

Person centred health care reviews were held every six months or sooner if required and involved the person who used the service where they had the capacity to be involved. Where issues were identified these were noted and follow up action recorded. People's weights were recorded monthly or more frequently if necessary. This meant staff could respond appropriately to help make sure people's health and wellbeing was maintained. We saw people's care and support records were clear, detailed and completed accurately with staff signatures and dates recorded to reflect the care and treatment provided.

We saw that information about a person whose skin integrity had declined highlighted the areas of concern or risk. This included the equipment to be used and frequency of care worker interventions in relation to the person's repositioning and diet whilst being cared for in bed. This person's care record gave clear and detailed information for staff to follow in order to minimise the risk of the person developing pressure sores. During the inspection the registered manager was alerted through good care worker monitoring and observations of further decline to the person's skin integrity. We saw that the registered manager immediately spoke with the visiting district nurse to seek advice about the person and how best to manage repositioning them. The deputy manager and registered manager updated the persons care record to include the advice given by the district nurse and a referral to the tissue viability nurse was made for the person. We saw records to show that the registered manager shared the updated information with the care workers on duty to make sure they knew what to do to meet the persons changing needs. When we visited the person in their room we found them to be comfortable and able to engage with care workers about their diet and what they wanted to drink. A body map to record and highlight any bruising or injuries sustained, was kept in the persons care record. This meant that people's care records were person centred and they were protected from the risks of poor skin integrity, inadequate nutrition and dehydration.

We observed care workers were vigilant in their observations responding positively to two people who preferred to walk around the home as part of their daily routine. We saw that care workers made regular checks on both people's whereabouts and constantly offered each person drinks and snacks throughout the day. The registered manager said, "We always make sure [Person's name] is provided with several drinks and something to eat on their travels. It's important to make sure they don't get dehydrated. We have high calorie drinks prescribed by their GP and food such as cakes, sandwiches and biscuits ready for them to eat because they're prone to weight loss with all the walking they do". During our observations we saw both people were encouraged to drink and eat small snacks such as freshly made sandwiches, fruit and biscuits

which had been placed in areas they were known to frequent such as the office and shared lounge. When we examined both people's care records we saw that the home had followed the advice from health professionals to make sure their nutrition and hydration needs were responded to appropriately.

We saw there was a daily plan of scheduled activities displayed on the home's notice board and we saw that people were supported to take part in these activities where possible. On the second day of our inspection we observed two care workers involving people in a reminiscence activity in the main lounge. We saw people taking part in a word game activity where they were asked to complete familiar phrases or words. It was apparent people were enjoying calling out the answers in response to the care workers questions. A care worker spoken with said, "It's not often people want to get involved in the activities we have on offer. Most people prefer to spend time in their rooms, listen to music or watch TV. People seem to like this game and they have fun too". Some people had their pets living with them. We observed a person interacting with their pet which gave them comfort. A pet health and safety policy and risk assessment was in place.

A complaints policy was in place. The policy in place allowed for a full investigation and all complaints were taken seriously and would be escalated to the local government ombudsman if the complainant remains dissatisfied with the outcome. We reviewed a selection of a small number of complaints the service had received in the last year and noted the manager had followed the organisations complaints process. Actions had been recorded and the complaints resolved to all parties satisfaction.

Good

Is the service well-led?

Our findings

At this inspection we found that the business had been sold and a new provider was registered with the Care Quality Commission. The current registered provider was not on site during this inspection.

Systems were in place to monitor and improve the quality of care provided and included audits to ensure safe, effective, caring, responsive and well-led care was provided to people. We examined records that showed issues raised from a system of audits carried out were reviewed and actioned. For example, the registered manager had completed an audit tool checklist to be completed bi-annually. We examined the most recent checklist that was completed in January 2017. This tool gave an oversight of the systems in place used to verify the monthly checks in relation to safeguarding, protecting people from avoidable harm, employee recruitment, staff training, medicines management, infection control, care records, complaints and environmental checks.

The registered manager evaluated these systems to determine if they conformed to the services policies and the regulations. The system also identified and measured good practice which helped to drive forward service improvement. However, although the registered manager had identified particular environmental areas for improvement, such as redecorating and replacing carpets in the shared lounge, due to the sale of the home any action required to address the identified areas, had not been progressed by the previous provider.

The registered manager was successful in ensuring the continuation of minor home improvements and maintenance of the home was completed, such as repairs to door handles, cleaning equipment and some soft furnishings. The new registered provider was not present during this inspection. However we examined a business development plan which had been drawn up to include a three year service development and building renovation plan. The registered manager told us that after meeting with the new provider they were enthusiastic about the planned developments.

A registered manager was in place at the time of our inspection and was present at both days of the inspection. 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.

Care workers told us they felt supported by the registered manager and enjoyed working at the home. They told us they were happy in their work and had continued working at the home because the registered manager continually supported them in their work and they felt valued. It was apparent staff were happy with their employment and care workers we spoke with said, "It's not an easy job but I enjoy what I do" and "It's hard work but we're like a family here" and "The manager is really helpful, we want to do a good job for them and the resident's. We all look after each other".

We saw records to show that the registered manager had continued to organise and lead a range of regular

meetings such as kitchen staff meetings, day and night care worker meetings and senior care worker meetings. The meeting records we examined showed that these meetings had taken place during February, March and April this year. They showed a recent staff meeting was held to discuss the changes to the laundry procedure and practices and the importance of good infection control. This meeting was attended by staff in various roles. Meeting notes were kept to ensure an accurate account of people's verbal contribution. Care workers spoken with told us that the meetings helped them to share and communicate particular issues in relation to the home and people who used the service. This meant all staff were regularly supported to ensure their knowledge and practice was up to date and consistent throughout the service. The registered manager had planned to hold a meeting with the staff team to discuss the service business plan following a management meeting with the registered provider in May 2017.

A business contingency plan was in place which identified the provider actions when an exceptional risk would have impact of the service provided to people and staff. Having a business contingency plan is an essential part of any services response planning. It sets out how the business will operate following an incident and how it expects to return to business as usual in the shortest possible time afterwards.

Accidents and incidents were recorded and had been regularly monitored by the registered manager to ensure any trends were identified and addressed. Any safeguarding alerts were recorded and checked for any patterns which might emerge. We were told that there had been no identifiable patterns in the last 12 months.

The registered manager understood their responsibilities to provide notifications to the Care Quality Commission (CQC) regarding significant events such as; serious injuries and deaths. Before this inspection we checked our records to see if appropriate action had been taken by management to ensure people were kept safe. We saw that the registered manager had completed and sent to the CQC appropriate notifications as required.

The registered manager shared with us copies of the services policies and procedures such as, complaints and suggestions, safeguarding adults, accidents and incidents, medicines, staff recruitment and whistle blowing. All of the policies we looked at had been reviewed regularly and the next policy review date was planned.