Millcroft & York Lodge Care Homes Limited

Millcroft

Inspection report

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East Sussex
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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

We inspected Millcroft on 13 September 2016. The inspection was unannounced. Millcroft is a residential care home registered to provide accommodation and personal care for a maximum of 24 people. The home specialises in providing care to older people. At the time of our visit there were 16 people living in the home. At the time of our inspection there was a registered manager at the home. 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.

Risks to people's safety had been assessed and actions taken to protect people from the risk of harm. The provider had systems in place to protect people against abuse and harm. The provider had effective policies and procedures that gave staff guidance on how to report abuse. The registered manager had robust systems in place to record and investigate any concerns. Staff were trained to identify the different types of abuse and knew who to report to if they had any concerns.
Medicines were managed safely and people had access to their medicines when they needed them.

Staff were well trained with the right skills and knowledge to provide people with the care and assistance they needed. Staff met together regularly and felt supported by the manager. Staff were able to meet their line manager on a one to one basis regularly. There were sufficient staff to provide care to people throughout the day and night. When staff were recruited they were subject to checks to ensure they were safe to work in the care sector.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People had enough to eat and drink, and received support from staff where a need had been identified. People's special dietary needs were clearly documented and staff ensured these needs were met.

The staff were kind and caring and treated people with dignity and respect. Good interactions were seen throughout the day of our inspection, such as staff sitting and sharing mealtimes with people as equals. Staff knew the people they cared for well and treated them with kindness, compassion, dignity and respect. People could have visitors from family and friends whenever they wanted. People spoke positively about the care and support they received from staff members.

People received a person centred service that enabled them to live active and meaningful lives in the way they wanted. People had freedom of choice at the service. People could decorate their rooms to their own tastes and choose if they wished to participate in any activity. Staff respected people's decisions.

People felt well cared for and were supported with a variety of activities. However, activities were not always structured meaning that people could potentially become under stimulated. We have made a recommendation about this in our report.

Support plans ensured people received the support they needed in the way they wanted. Peoples health needs were well managed by staff so that they received the treatment and medicines they needed to ensure they remained healthy. Staff responded effectively to people's needs and people were treated with respect. Staff interacted with people very positively and people responded well to staff.

The culture of the service was open and person focused. The registered manager provided clear leadership to the staff team and was an active presence in the home.

Audits to monitor the quality of service were effective and embedded. They identified actions to improve the service and these had been carried out.

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 were protected from avoidable harm and abuse.

Risk assessments were comprehensive and reduced hazards.

The provider had ensured that there were sufficient numbers of staff in place to safely provide care and support to people.

Medicines were stored and managed safely.

Is the service effective?

Good

The service was effective.

Staff received training that gave them the skills and knowledge required to provide care and support to people.

Consent was being sought and the principles of the MCA complied with.

People had access to a range of food options that was nutritious and met their needs. People were supported to maintain their diets when required.

People's healthcare needs were being met with support to routine appointments and appropriate referrals.

Is the service caring?

Good

The service was caring.

Staff knew people well and used the information effectively. People and their families were involved in their lives.

People were treated with respect and their independence was encouraged.

Is the service responsive?

Good

The service was responsive.

People received a person centred service and staff responded effectively to people's needs.

Complaints were responded to appropriately

Is the service well-led?

Good

The service was well led.

The culture of the service was open, person focused and inclusive.

The management team provided clear leadership to the staff team.

Quality monitoring systems had been effective and led to change.

Millcroft

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 13 September 2016 and was unannounced. The inspection team consisted of two inspectors.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. Before the inspection, the provider completed 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.

As some people who live at Millcroft were not consistently able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. As part of the inspection we spoke with the registered manager, head of care, maintenance manager, three care staff, six people and four people's relatives. We looked at a range of records about people's care and how the service was managed. We looked at five people's care plans, medication administration records, risk assessments, accident and incident records, complaints records and quality audits that had been completed. We last inspected Millcroft in November 2013 when we found the service was compliant in all areas.

Good

Is the service safe?

Our findings

People felt safe living at the service. One person told us, "I never think about safety because I feel safe here." One relative told us, "I absolutely feel my mother is safe at Millcroft. She ended up there after she was unable to care for herself. I can sleep well at night. I came away today knowing that she's safe where she is." People were protected against the risks of potential abuse. Staff were knowledgeable about safeguarding risks and their roles in protecting people. One staff told us, "We have training in safeguarding and it's all about keeping people safe and looking out for the different signs of abuse." Another member of staff told us, "If I saw or suspected something I would take the person away from the situation so nothing more can happen. I would call my manager, the police and social services." Staff also commented, "If I suspected abuse, like hitting, I would report it as a criminal offence or call the manager. Before I would remove the person from the harm and then call emergency services like police and then contact adult social care." Staff were able to talk confidently about the reporting procedure and the different types of abuse. They also knew what potential signs to look out for, such as a change in behaviour, in order to be vigilant against potential abuse and keep people safe. Records showed that the service was pro-actively reporting safeguarding alerts. The safeguarding folder contained information on three recent referrals where the correct process had been followed and the service had been open in their dealings with other agencies.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. Positive risk taking was being encouraged in the service and there were examples of this in how the service supported people with known hazards. One person had moved to the service with a history of falls. However, a falls risk assessment had been completed and recorded a low risk to the person. This level of potential hazard was upheld in monthly reviews. Despite the history of falls the person's mobility care plan carried through the low level of risk identified in the falls risk assessment and directed staff to support the person to walk independently. Observations on the day of our inspection showed that this was happening. The service used positive behaviour support principles effectively in order to keep people and staff members safe. One person's care plan showed that there was an effective plan to manage their anxiety. This was achieved by looking at different presenting behaviours, the triggers for each behaviour, any action to prevent the behaviour and a review after each incident. The person themselves had been involved in writing the plan and had reviewed it regularly.

People's care plans considered risk in a structured way that kept people safe. People who were at risk of malnutrition had nutritional risk assessments in place. The provider had consulted national guidance and implemented the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under-nutrition), or obese. The MUST tool enables provides to monitor people's risk of malnutrition and acts as a baseline assessment. Records showed that the MUST was being recorded monthly for people who were at risk of malnutrition. At the end of each care plan was a 'management of personal risks' form which summarised risk areas including emergency evacuation. This meant staff could easily see the areas of risk for each person and support them safely.

People told us they felt there were enough staff on duty to meet their needs. One person told us, "There's

enough staff; you can always find them or ring the bell for them." Another person commented, "There's plenty of staff, especially when they change over and when we press the buzzer they're always prompt in responding." The service used a call bell system for people to be able to call for staff and people had been assessed to check that they could use the call bell. Records showed that for August 2016 the longest time before a call bell was answered was one minute and 15 seconds. This meant that people were being responded to promptly by their support staff. Staff told us, "We only have 16 residents and it is calm and collected and it helps that we have a good team: we all work together." Staffing levels were adjusted if people's needs changed and past rotas reflected this. Staff said that they would often be allocated to support a person on a one to one basis if they became unwell and needed additional support.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible.

There were safe medication administration systems in place and people received their medicines when required. An administration round was observed and all dispensing was done from a trolley, which was locked between each administration. The staff member administering gave full attention to the task and spent time with each individual, ensuring they understood what was being offered, and why. Where medicines were to be given 'as required', for example to relieve pain or indigestion, there were written protocols with the medicine administration record. These indicated whether people would be asked if they needed the medicine, or whether the staff member would need to use prompts and consider how the person presented. People were given time to decide whether as required medicines would be given.

Staff supported people to understand the reasons why they took their medicines. One person had completed a course of treatment but had been given a second course by their GP. This person was reluctant to take their tablets and told the staff administering medicines that they didn't need or want them. The staff member spent a long time with the person, explaining it was the GP's advice to take the medicine, reminding the person how unwell they had been and why the GP thought they were still unwell. The staff member then supported the person to read the box and label after which they decided to take the capsule. It was noted that the person appeared visibly better later in the day as a result of the staff member's support. People who needed topical creams applied had a body map with the medicines administration record (MAR) sheet, which showed staff what the cream was for and where it was to be applied. The registered manager had carried out regular audits of medicines to ensure that they were being administered, stored and managed safely. Records showed that the audits happened regularly and staff members knew that medicines were checked regularly.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One relative told us, "I feel the staff have the right training and I can tell them what I think should happen. For example, I spoke to the manager and said I wanted X to come home to me to have lunch and the staff couldn't have been more helpful: they were brilliant." One person told us, "The staff are always so nice and patient with us. They always help with what we need and they do their job with a smile; they're incredible".

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff told us, "We had dementia training, which helped me to realise how reactions in residents are related to their dementia and why they cannot remember things in the short term. I also learned about all different types of dementia and how their behaviour reacts to us, for example if they're upset during personal care, and that this is the dementia and not the person." Records showed that there was a comprehensive training programme in place to meet people's needs. Courses were available to staff in areas such as moving and handling, infection control and food safety amongst others. The registered manager had ensured that all staff had received a comprehensive training programme and that training was kept up to date with regular updated courses. There was a full induction programme in place. Staff told us, "The induction was really good. There was shadowing, induction paperwork, and an introduction to the residents and the staff. I shadowed four shifts until I was confident and also finished my NVQ here". Another staff told us that newer staff often attend outings in the minibus as it was a good way to appreciate people as personalities and to help develop communication with them: "I found that really helpful in my early days at the home".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had ensured that people's freedom had not been restricted and systems were in place to keep people safe. Records showed that the service had made appropriate referrals for DoLS and were using the principles of the MCA to protect people. For example one person had been assessed as able to make day to day decisions, for example what to eat, wear, or do. However, they were also diagnosed as having a condition that altered their ability to understand. As such, a MCA assessment was completed which showed they were unable to make certain decisions and a DoLS was applied for.

People appeared to enjoy mealtimes and have access to the food and drink they liked. One person told us, "The food is very good and if it's something you don't like they give you something else. They ask for suggestions and I asked for a pork pie [because of where I am from] and the next day they had one for me." Catering was all based on provision by a commercial catering contractor. The contractor designed the menu, which provided for a choice of hot meals and sweets at lunch and tea times. Meals were delivered as

frozen and were heated according to clear instructions in an oven specific to this purpose and temperatures of the food were regularly being checked before it was served. The menu for the day was written up in the dining room and people were asked earlier in the day for their choices. Staff were seen to take time over assisting people to make their choices and it was not a problem if people changed their mind at the table. People chose whether to eat in the dining room or in their rooms. The preparation and service of meals was efficient and was an integrated part of care workers' duties. Meals were served in an attractive way, were not rushed and appeared to be enjoyed. The tables were set with cutlery, napkins, salt and pepper, vinegar, flowers and a choice of three cold drinks. On the day of our inspection 12 people were served a meal at their tables within a ten minute timeframe. Staff ate at the table with people, which added to a pleasant atmosphere, with people and their staff members engaged in conversation about the food or their plans for the day. The timing of the lunch time meal was adjusted to fit with those who went out on the morning's minibus outing.

The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. One person's care plan identified that they needed a plate guard to eat independently and this was provided during the meal. One staff member told us, "We have a menu with the choice of two meals, side orders of potatoes or veg and puddings. If people don't want that we have a spare stock of food and we write down what's available and they chose from that and we also have sandwiches and soups." Another staff member told us, "We have four diabetics here and they send a good selection of diabetic food and deserts." People's needs and preferences were also listened to and respected. The service bought some food locally to supplement the pre-prepared menu, for example to extend the choice of cakes and pastries and to maintain a ready supply of fresh fruit. Records and observations showed people had their preferred breakfasts at times of their choosing and that hot and cold drinks were made available at all times of day and night. One person told us, "There's always a basket of fruit and we can help ourselves."

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People had a health action plan which described the support they needed to stay healthy. One person's care plan had been started on day of admission. Two subsequent reviews showed they had been seen by their GP and had a course of antibiotics for a chest infection, and been referred to the dietician, resulting in the prescribing of a nutritional supplement. This was health need was developed in the nutrition care plan. A referral to the dietician had been made when weighing records showed a weight loss. The next recorded weight showed a weight gain, meaning the person was having their health needs met by an integrated care approach. Staff members were able to describe how best to support the person to eat, in line with the information recorded in the care plan. Support workers also knew precisely the degrees of the person's weight loss and gain.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. One relative told us, "Staff have facilitated all the appointments and my mum has been able to see a Dr when she needs to". One person had been admitted to hospital for a chest infection. The person had deteriorated whilst in hospital, had lost weight and also lost certain functions, such as the ability to feed themselves. On return to the service staff contacted the person's GP and had their diet fortified. Staff noted a difference in the person's presentation, in that they had either taken a long time to respond, or had not responded at all to questions. The service arranged for the GP to refer the person for a hearing test. Records showed that over two months after moving back to Millcroft the person had gained weight and was able to feed themselves again.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "I honestly couldn't find anywhere nicer to live. To me the staff are family and that's the way they treat me." Another person commented, "The staff are so caring and I really can't fault any of them" whilst another person commented, "This place is 11 out of 10, I can't fault it. I find the staff very nice, they are fantastic." A relative told us, "They [staff] are very kind and caring not only to my mother but to me. When I needed it most they were a great support. The staff make visiting the home a pleasure as they talk to me as well."

People received care and support from staff members who had got to know them well. The relationships between staff members and people receiving support demonstrated dignity and respect at all times. One person told us with good humour, "They [staff] know me well: too well sometimes. The staff are regular: they know us and we know them, and we know who's on each day as there's a list on the wall." Staff interacted with people in a way that people enjoyed and that respected people's choices around communication. People were able to say "here comes trouble" when staff greeted them and staff would engage with them, gently joking and joining in by laughing and calling each other a liar when a person joked that a staff member was naughty. This was done with very good humour and created a friendly and happy atmosphere that people clearly enjoyed. For other people a more formal approach was used. One staff member told us, "When we first met, Mrs X asked me to call her by her last name. We know that she used to be a nurse and this is how she had to address people as a nurse, so we address her formally as Mrs X."

On the day of our inspection we observed very open, familiar relationships between residents and staff and these were apparent throughout the day. Staff members described looking in regularly on people staying in their rooms and our observations confirmed that this happened. Although these visits were not being recorded due to the small size of home, the staff members viewed it as a natural part of their caring role. A staff member noticed that one person who was sleeping in the lounge had shivered, so they went to fetch a blanket and gently wrapped it around the person. The person woke up and smiled at the staff member and said "lovely".

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. Staff told us, "According to MCA we assess people's capacity and see who can make decisions and for those people who cannot we make decisions with relatives and their GP. For small day to day decisions we promote independence and every day we ask when people want to get up, what they want to wear, which colour dress, what they want to eat, so if people don't like a choice on the menu we ask what they do want, like egg and bacon or pork pie etc. Some people like to go for a cigarette or a walk and if that's their choice we support them to do that."

Staff knew people's individual communication skills, abilities and preferences. Three people were in the lounge. They talked between themselves in a natural way, between short sleeps. The TV was on but taken no notice of, however a staff member asked them if they wanted a change of programme or the TV switched off and they said no. Another support worker came in to ask people's menu choices for lunch time, took time to explain what the meals were. The staff member was very patient with someone who used a pictorial menu

card to assist them to choose a meal and this meant that the person was able to make this choice for themselves. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. People's views were sought through care reviews and annual surveys.

Care plans captured peoples' voice and preferences so that they received the care and support they needed in the way they wanted it. Care plans contained a 'This is me' document which gave a wide picture of people's past life and more recent experiences, as well as what things were important to them. One person's was written to show it was very much based on the person's own words so it was a lively and meaningful document. "I find things to do. I like to walk around, keep active. I like to sit and read the paper in the mornings." This was seen to be an accurate reflection of how the person spent her day, and how staff described them. The use of quotes from the person was carried into each section of the care plan. For example, the health section began with the person's perception of their own health needs. Records showed that people's voices were used to populate care plans consistently across the plans we saw.

People's dignity was respected by staff. One staff told us, "We support everyone as an individual but we treat people equally. We give people choice to find out their personalities and we let them speak and decide things for themselves." Care plans recorded people's personal care needs and any assistance that was needed was described effectively. One person's plan placed an emphasis on their own abilities to maximise their independence and also contained a provision for their privacy and dignity. The continence care plan struck a balance between the person's own stated perceptions and staff observations of where support needs were indicated. In light of the person's short term memory loss, there was a care plan action to improve signage to the nearest toilet and this had been carried out. This meant that the person was able to maintain their independence for as long as possible without any impact on their dignity.

Good

Is the service responsive?

Our findings

People were receiving a person centred service. One staff member told us, "We don't treat everyone the same. You get to know people and their interests, what they like to talk about and their sense of humour. You have to be different with different people. For example I know that X likes a joke and Y likes to joke around and have fun with their staff, whereas Z is more formal, so we adjust how we are when we're supporting people." One person told us, "The staff are so lovely, if you wake up in the night and ask for a cup of tea they bring it straight away, and it's those little things like getting a cup of tea when I would like one that really matter to me. I don't think you could find a better home."

We found that that staff were responsive to people's needs and demonstrated a good knowledge and understanding of the support people required. People were assessed to enable them to make decisions for themselves and live in the way they wanted, even if staff members or relatives did not agree with their decisions. A member of staff told us, "One person will only go out for a cigarette and will not do any activities. We were worried they were being isolated so the GP, community psychiatric nurse, social worker and the person's family were all involved in a best interest meeting around self-neglect as to whether this is the best environment for the person. It was decided that she was in the best place here. It's just that she doesn't like staff going in and out of her room and it annoys her if we go in without her ringing the bell and calling us. The family and everyone agreed the best way to support her and that's what we do as it's what the person wants."

People and their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. One relative told us, "We've only recently moved mum there and I have asked the manager for requests such as if she can have hair done and see a chiropodist and these were facilitated. I got feedback when I asked if she had gone out and how she's getting on with the residents." One staff member told us about the process for reviewing care plans. They informed us that all staff were involved in discussing the person when the review was being done, "because the person doing the review may not have such a good relationship with them, or may only know them in certain situations. And we always tell the person we are reviewing their care, and involve family if they want." One relative told us that they were invited to reviews and were also involved in other decisions, "I am involved in decisions so is my brother who phones the home and speaks to staff to find out how she is. She had to go for a hospital appointment and it's easier for them to deal with it as she gets anxious about leaving the home and they did it for me. They gave me a good contract and talked to me about what my mum likes and what she doesn't like. The contract was really impressive and the care they had taken impressed me."

People and their relatives spoke highly of the service that they and their loved ones received. One relative told us, "I can tell you the end of May I was nearly having a crisis with mother and Millcroft eased it all and helped me greatly. My mum had a bad transition from hospital to the home but they were very good at reassuring me she would settle and they reassured me every time I went and rang." Another relative told us, "They care for my mum and for me it's the most important thing and they make me feel mum is safe she's looked after, getting her meds and is so much better than she was before she moved there. Since she's

moved to Millcroft we've seen a real improvement." One person told us, "The staff look after me so well and I feel I can ask for any help I need." Another person told us, ""They know me so well, they talk to me and know what I like and how I like to be treated."

Activities were available but were not always planned effectively. One person told us, "We play skittles, go out about two or three times a week." Another person commented, "We go out in the minibus and stop off for tea, coffee and biscuits." The registered manager used a diary for recording activities in the home. However, this was not a robust record. For example, one entry was "a.m. minibus outing – ride out" with no indication of who went, or where they had visited. Other entries showed, "X went out with son, Y's daughter visited." For one Saturday there were lists of who had watched the TV for a.m. and p.m. and 3 people just listed as "Newspaper." There was a visit from a pet's as therapy company and a list of who was involved, but no indication if anyone was invited and declined, or of people's responses. Some entertainers were listed ahead in the diary. Activities provided were mainly passive, other than joining in singing. Staff said there had been baking sessions, a resident who assisted planting in the garden, another who liked to have and use a duster. However, there was no evidence of purposeful planning.

Support staff were expected to initiate activities, such as bingo, on the basis of suggesting things or seeing what residents might ask to do. The registered manager told us, "It's up to the residents what they want; we are here to support them. So the records show how people have chosen to spend their time." The registered manager agreed that the activity diary could be used for forward planning of ways to meet individually identified interests. The service had advertised unsuccessfully for an activities coordinator and intended to appoint one through further recruitment. However, the lack of structured activities meant that some people could potentially be under stimulated.

We recommend that the registered manager reviews the way that activities are planned and implements an effective recording process.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The service records all complaints in a complaints log and there had been four complaints recorded in 2016. One complaint was lodged by the registered manager to a transport company after two hospital appointments had been missed due to transport not turning up to take a person to hospital. The complaint had been responded to and there had been no issues with the transport company since. Another complaint from a person about their bed not being made was upheld and had resulted in extra bedding being purchased. The registered manager had written to the person the next day and the person was satisfied with the resolution.

One complaint from a medical professional was not upheld by the local authority as the service had respected a person's wishes not to seek earlier medical intervention. Records showed that this person had capacity to decide that they did not want to seek medical help and the service had respected this decision. One relative commented, "I can't think of any complaints. There may be little things like mum's clothes aren't in the wardrobe but it's nothing major and I give them the clothes and its fine. There's nothing I would lose sleep about. When I pointed this out the staff apologise and they put it right straight away and kept an eye on things going forward".

Good

Is the service well-led?

Our findings

The registered manager and the management team provided leadership to the service. One staff told us, "The manager provides leadership and she will make changes where she sees it is needed. I think that she is a good leader because she is knowledgeable, approachable and friendly. Even if she doesn't know something she tells you she doesn't know and then goes and finds out. When I need to know or understand anything she takes the time to sit and explain it to me." One person was able to name the area manager and the registered manager. They told us, "[the registered manager] is very friendly, very caring and very aware of what's going on. She has a knack of sorting out any problems: she is excellent." Another person commented, "[the manager] is brilliant. She is on the ball."

The management team were actively involved in raising standards and making improvements. The registered manager regularly conducted a monthly audit which detailed an inspection of all downstairs rooms, communal bathrooms, upstairs bedrooms, lounge area and the office. The audits had generated actions such us, "toilet window needs cleaning" and action had been taken to correct the actions. There was also a more detailed three monthly audit undertaken by the registered manager. Records showed that this was identifying issues and action had been taken to address the issues identified. For example, one audit had identified that a toilet needed to be re-decorated and this had happened. The area manager regularly visited the service to conduct checks and audits. These audits were structured and generated an action plan that was sent to the registered manager for completion of the actions. Records showed that actions had been completed and checked by the area manager on subsequent visits.

The registered manager sought feedback from relatives and professionals. In March 2016 surveys were sent out to relatives and professionals, such as GP's, district nursing team and other visiting professionals. A separate survey was sent out to relatives in March 2016 and the information generated was used to inform actions such as buying more in house activities for people and creating a quiet area in the conservatory.

The service promoted a positive culture that is person-centred, open, inclusive and empowering. Professionals and relatives were encouraged to visit at any time. One relative told us, "I think it is well managed and they seem to get on with the job at hand. I make sure I go at different times for my own sake so I can see how it really is and I don't have any worries. If mum has a fall they always let me know and reassure me and tell me what's going on. I have confidence in what they do." The registered manager told us, "I have an open door policy and people can come anytime and I listen to them. Staff knock on the door all the time. People also have the opportunity to express themselves in the residents meetings and staff meetings." Records showed that staff and residents meetings were held regularly. Residents meetings had generated many positive comments about the service, such as, "my bedroom is always clean". Any changes to the service were discussed with people beforehand, such as the re-painting of the corridors. The registered manager told us, "The dining table needed to be changed so we asked residents about it and discussed it in the meeting and decided on which one to buy".

The registered manager had a clear vision for the service and relatives were empowered to contribute to improve the service. The registered manager promoted relatives having a voice on appropriate decisions

that were made in the service. The registered manager saw this as part of the person centred service that was delivered. The registered manager commented, "We provide person centred care, value people's choices and promote dignity. If we need to change something we involve residents and relatives. For example one relative suggested using a tagging system for their loved one's laundry and we implemented it and found it worked really well."

People benefitted from having a staff team that was supervised and assessed regularly by the management team. People were receiving regular supervisions and appraisals. New staff members were supported to work through a structured induction programme. The registered manager had used a supervision calendar that showed all staff received an annual appraisal in February 2016, followed by supervisions in every three months on a rolling planner. Future supervisions had been booked in with staff members. Supervisions were conducted by the registered manager and recorded using a standard format that examined the staff member's working role, issues relating to people who lived at the service, staffing issues, training or development and any other issues. Records were full and signed by both the staff member and the registered manager, as per the supervision contract. One person's supervision record showed that they were being supported towards obtaining the QCF Level 5. This is a vocational qualification for management level roles in the health and care sector. This showed that the registered manager was supporting staff to develop their skills in their current roles.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager confirmed that no incidents had met the threshold for Duty of Candour.