Croftwood Care Ltd

Thorley House Residential Care Home

Inspection report

Hazelmere Gardens
Hindley
Wigan
Lancashire
WN2 3QD
Tel: 01942255370
Website:

Date of inspection visit: 05 January 2016
Date of publication: 22/02/2016

Ratings

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

Overall summary

This comprehensive inspection took place on 05 January 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. At the time of the inspection, there were 37 people living at Thorley House.

Thorley House is registered to provide personal care and support for 40 people. The home is situated in a quiet residential area of Hindley, Wigan, with enclosed secure garden areas.

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

Summary of findings

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.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. The service took into account people's needs and their dependency level, using a dependency level tool.

We looked at six staff personnel files and there was evidence of robust recruitment procedures.

There was an up to date safeguarding policy in place. Care staff demonstrated an awareness of safeguarding and were able to describe how they would make a safeguarding referral. The home had a whistleblowing policy in place.

We saw requirements relating to controlled drugs were being met. Controlled drugs are certain medicines that are subject to additional legal controls in relation to their storage, administration and disposal.

We saw the member of staff who was administering medicines left the medicines trolley unlocked and the door to the room where it was stored open on repeated occasions. Although no-one approached this area whilst staff were administering medicines, this is poor practice and would increase the risk of inappropriate access to the medicines.

There were no cream charts in place. Staff told us they administered cream medicines then told a senior carer who signed the MAR. There were body maps in place, and these were in peoples' MAR charts so may not have always been accessible to care staff to ensure they knew where to apply creams.

The home was clean and free from any malodours. Bathrooms had been fitted with aids and adaptations to assist people with limited mobility when bathing and toileting. There were a variety of cleaning schedules in place.

There was an accidents/incidents record book which had been appropriately completed and identified the detail of any incident including the cause and the detail of any immediate and subsequent action that was required to minimise any further risk.

Staff were subject to a formal induction process and probationary period. Supervision sessions for care staff were frequent. Comprehensive staff training records were in place.

The service was complying with the conditions applied to DoLS authorisations and staff told us they had received training in the MCA and DoLS. Staff were aware of how to seek consent from people before providing care or support. People's care plans contained records of visits by other health professionals. Staff were aware of how to ensure people's privacy and dignity was respected.

There was a five week seasonal menu cycle that was nutritionally balanced.

There were some adaptions to the environment, which would assist people living with a dementia.

People were treated with kindness and dignity during the inspection. Care staff spoke with people in a respectful manner. Care staff knocked on people's bedroom doors and waited for a response before entering. We heard lots of laughter between staff and people and there was a positive atmosphere within the home.

People's communication support needs were well documented in their care plans. At the time of the inspection no person was in receipt of end of life care. Peoples' bedroom had their picture on the door which would assist people living with dementia to find their own room.

There were records of residents and relatives meetings where discussions had resulted in changes being made within the service. Notice boards contained information on activities on offer.

Care plans were person centred and would allow staff to provide support in line with people's preferences. People had pre-admission assessments in place, which considered their support requirements. However, the pre-admission assessments we looked at were limited in the information they contained, were not fully completed and had not always been signed by the assessor or person being assessed.

Relatives of people we spoke with told us they knew what action to take if they needed to make a complaint. They

Summary of findings

told us they had never had to raise a complaint, but would feel comfortable doing so if required. The home had procedures in place to receive and respond to complaints.

Staff said they liked working at the home and told us they thought the home was well led and said that the registered manager was approachable and fair.

There was a full range of policies and procedures in place which were available in paper copy format and electronically.

The service undertook a range of audits, which were competed according to different schedules.

There was evidence in minutes of team meetings that findings from audits were communicated to staff and actions taken.

Accident and incident forms were completed correctly and included the action taken to resolve the issue and the corresponding statutory notification form required to be sent to CQC, where appropriate.

The service worked alongside other professionals and agencies in order to meet people's care requirements where required.

There was a business continuity plan in place that identified actions to be taken in the event of an unforeseen event.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People we spoke with who lived at Thorley House told us they felt safe.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. The service used a dependency level tool to determine staffing levels.

There was evidence of robust staff recruitment procedures.

Good

Is the service effective?
The service was effective.

Staff were subject to a formal induction process and probationary period and comprehensive staff training records were in place.

Staff were aware of how to seek consent from people before providing care or support.

There were some adaptions to the environment which would assist people living with a dementia to orientate around the building.

The home was clean throughout and free from any malodours.

Good

Is the service caring?
The service was caring.

We observed people were treated with kindness and dignity during the inspection.

Throughout the course of the inspection we heard lots of laughter between staff and people and there was a positive atmosphere within the home.

We saw records of residents and relatives meetings where discussions had resulted in changes being made within the service.

Good

Is the service responsive?
The service was responsive.

Care files were well organised and contained care plans that covered a range of health and social care support needs.

People we spoke with told us they had never had to raise a complaint, but would feel comfortable doing so if required.

One person's care plan did not accurately reflect the support they required in relation to moving and handling.

There was a complaints policy and procedure in use and this was up to date.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

There was a registered manager in post.

Staff told us they thought the home was well led and said that the registered manager was approachable and fair.

Residents' meetings had been held regularly. Records of these meetings were detailed and showed that various issues had been discussed.

The service undertook a range of audits, which were competed according to different schedules.

The service worked alongside other professionals and agencies in order to meet people's care requirements.

Thorley House Residential 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 comprehensive inspection took place on 05 January 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. At the time of the inspection, there were 37 people living at Thorley House.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents. We also contacted Wigan Local Authority Quality Assurance Team, who regularly monitors the service and the local Healthwatch. Healthwatch England is the national consumer champion in health and care. We did not request a provider information return prior to the date of the inspection.

We spoke with six people who used the service, two visitors and seven members of staff including care staff the registered manager and the proprietor. We also looked at records held by the service, including five care files and six staff personnel files.

As part of this inspection we 'case tracked' care records for people who used the service. This is a method we use to establish if people are receiving the care and support they need and that risks to people's health and wellbeing were being appropriately managed by the service.

We observed care within the home throughout the day including the morning and lunchtime medicines round and the lunchtime meal.

Good

Is the service safe?

Our findings

People we spoke with who lived at Thorley House told us they felt safe. A person who used the service said: “If I want anything, I get it quickly.” Another person told us: “The staff are very nice. You can use the call bell and they attend.” Another person said: “The girls are always there and will help you.”

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. We looked at the staff rotas for December 2015 and January 2016 and these consistently demonstrated that there were sufficient care staff on duty to meet the needs of people who used the service. People who used the service, visitors and staff told us they thought there were sufficient numbers of staff on duty to meet people’s needs.

A visitor to the service said: “There are always enough staff when I visit.” Staff told us the home did not use bank or agency staff and that it was possible to cover all shifts within the home from the existing staff group. Staff rotas confirmed that the service had not used any agency staff.

When determining the level of staff required to meet people’s needs, the service took into account people's needs and their dependency level, using a dependency level tool. From this information, which referenced peoples’ dependency in a variety of categories, including falls, nutrition, moving and handling and pressure sores, the home was able to identify safe staffing numbers relative to individual peoples’ needs.

We looked at six staff personnel files and found there was evidence of robust recruitment procedures. The files included application forms, proof of identity and references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant’s suitability to work with vulnerable people.

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. We spoke with three care staff who demonstrated an awareness of safeguarding and were able to describe how they would make a safeguarding referral. Staff were aware of potential signs of abuse or neglect and of how to report any safeguarding concerns appropriately. Staff told us they had contact numbers for the local authority safeguarding team on the wall in the office should they need it, which we observed during the inspection.

The home had a whistleblowing policy in place. We looked at the whistleblowing policy and this told staff what action to take if they had any concerns and this included contact details for the local authority and the Care Quality Commission. Staff we spoke with had a good understanding of the actions to take if they had any concerns.

We looked at how the service managed the administration of medicines. Records of administration had been completed consistently and accurately. We saw requirements relating to controlled drugs were being met, for example, we saw there were two signatures when controlled drugs were administered, which were stored in a separate, locked controlled drugs cabinet. Controlled drugs are certain medicines that are subject to additional legal controls in relation to their storage, administration and disposal.

We saw some people were prescribed medicines ‘when required’ (PRN), such as for pain relief. We saw PRN protocols were in place for these medicines. PRN protocols provided details about when such medicines should be given. Staff told us most people were able to indicate when they required their PRN medicines and we saw that pain scale assessments were used to help staff determine when pain relief was required for people who weren’t able to communicate this requirement verbally. The provider’s medicines policy stated there should be a specific plan in place for any PRN medicines, which we verified.

We were told a number of people living at the home were self-administering their medicines. We saw that an assessment was carried out for all people at the home to help determine if they wanted to manage their own medicines if this is was what they wished to do.

We observed staff administering medicines. We saw the member of staff who was administering medicines left the medicines trolley unlocked and the door to the room where it was stored open on repeated occasions. Although no-one approached this area whilst staff were administering medicines, this is poor practice and would

increase the risk of inappropriate access to the medicines. We spoke to the staff member who assured us that in future they would not leave the medicines room in a potentially insecure position.

We observed that people were given their medicines as required, but the member of staff did not always observe everyone to ensure they had taken them before returning to sign the medication administration record (MAR). This meant the staff member could not be certain if people had taken their medicines. We observed a second medicines round and saw that staff followed safe practices when administering medicines, observing people and signing the MAR as medicines were taken.

There were no cream administration charts in place. Staff told us they administered cream medicines then told a senior carer who signed the MAR. There were body maps in place, and these were in peoples' MAR charts so may not have always been accessible to care staff to ensure they knew where to apply creams.

During the inspection we looked around the premises. We saw the home was clean and free from any malodours. We saw that bathrooms had been fitted with aids and adaptations to assist people with limited mobility when bathing and toileting. We saw that liquid soap and paper towels were available in all bathrooms and toilets. The bathrooms were well kept and surfaces were clean and clutter free. We saw there were signs displayed that advised staff how to wash their hands effectively.

The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use. Radiators had appropriate guards to protect against the potential for burns.

Staff were aware of precautions to take to help prevent the spread of infection. For example, staff said they would wash their hands regularly and use different coloured cleaning cloths for different areas of the home. There was an infection control guidance manual for staff in place in addition to an infection control flowchart that identified to staff what actions to take to minimise the potential for an infectious outbreak and the action to be taken in the event of an outbreak. Pandemic flu guidance was also in place.

There was an up to date a fire policy and procedure. Fire safety and fire risk assessments were in place. People had an individual risk assessment regarding their mobility support needs in the event of the need to evacuate the building, which was easily available for staff to access. Staff we spoke with were aware of procedures to follow in the event of an emergency, such as if an emergency evacuation of the home was required in the case of fire or flooding. The provider had also carried out a fire risk assessment annual review in February 2015.

We saw people had risk assessments in their care plans in relation to areas including falls, pressure sores, and malnutrition. We saw that one person had recently fallen and we saw an accident report had been completed and the risk assessment reviewed and appropriate measures put in place to reduce risk. Another risk assessment we looked at had not been updated following a fall although other appropriate actions had been taken.

There was an accidents/incidents record book which had been appropriately completed and identified the detail of any incident including the cause and the detail of any immediate and subsequent action that was required to minimise any further risk. For example one person had missed a seat cushion whilst attempting to sit down on a chair. No injury had been sustained, but the service worked with the person and identified a safer method for sitting down such as feeling for the arms of the chair and placing the backs of the legs against the chair before attempting to sit down. Daily monitoring of this was in place. In other examples we saw that appropriate referrals had been made following an incident such as contacting the GP, the ambulance service or the falls prevention team.

Good

Is the service effective?

Our findings

A person who used the service told us: “The bedrooms are very nice. The beds are always made and sheets are changed regularly.” Another person said: “The food is alright. It could sometimes be better. It’s not cooked the way I used to cook.” Other people we spoke with told us they liked the food provided. One person told us: “You couldn’t get a better place. The food and the staff are number one. They will do whatever you want.”

We looked at staff training, staff supervision and appraisal information. The supervision schedule had recently been amended to reflect the need for four formal supervision meetings during the year. Annual appraisals had either taken place or where scheduled for after the date of the inspection. Supervision sessions for care staff were conducted by the manager who told us they received supervision from the area manager. We verified this by looking at the notes of staff supervision meetings. Staff told us they received supervision on a regular basis, which they found useful.

Staff were subject to a formal induction process and probationary period. We looked at staff personnel files and saw that there were records which referenced the successful completion of the probationary period and records of training undertaken during induction such as safeguarding, infection prevention and control and moving and handling.

Comprehensive staff training records were in place and staff had completed training in a variety of other areas relative to their job role, such as food hygiene, fire safety, dementia care, first aid and medicines safe handling and awareness. Staff told us they had received training in dementia care. The staff we spoke with were able to tell us about different forms of dementia and said they would meet the support needs of people living with dementia by providing prompting and reassurance.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw there had been seven applications for DoLS made to the supervisory body, and one of these had been authorised. The registered manager showed us records that demonstrated they had followed-up the status of the outstanding DoLS applications at regular intervals. 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. We found that the service was complying with the conditions applied to the authorisation. Where applications had not yet been authorised, peoples’ care plans contained restrictive practice screening tools, which ensured that the least restrictive practice was being followed.

Staff told us they had received training in the MCA and DoLS and most were able to explain the principles of this legislation to us. However, one member of staff we spoke with was not aware of what DoLS was. Appropriate supporting policies and procedures were in place, for example, the

service had policies on MCA/DoLS and safeguarding adults. We checked the training records and saw that 70% of care staff had completed training in MCA/DoLS. Other ancillary staff who did not provide care had also completed this training.

Staff were aware of how to seek consent from people before providing care or support. Staff told us they would always ask before providing care and would ensure any practice was the least restrictive option. Staff told us if people refused care, such as assistance with bathing or medicines, they had the right to do so. They told us they would ask people again later if they had refused care and follow this up with a manager if required. We saw people had mental capacity assessments in their care plans, which were up to date.

People’s care plans contained records of visits by other health professionals. We saw that a range of professionals including GPs, speech and language therapists (SALTs) and

Good

Is the service effective?

CPNs (community psychiatric nurses) had been involved in people's care. We saw people's weights were being monitored on a regular basis where a need for this had been identified.

When we arrived at the home there was an inviting aroma of food preparation and we observed the breakfast meal. We saw twelve people eating breakfast, which was cereal, toast, jam or marmalade and a warm or cold drink. There was also a choice of a hot breakfast on request, such as a full English breakfast. The service had achieved a food hygiene rating score (FHRS) of five. Fridges and freezers were well-stocked in addition to a plentiful supply of dry food goods.

There was a five week seasonal menu cycle, which was displayed both inside and outside of the dining room. People identified what they wished to eat each day and this information was given to the kitchen. We saw the chef came round and asked people what they wanted for their mid-day meal. Special diets were catered for, food allergies were recorded and people had nutrition and hydration care plans in place. Food temperatures were recorded at each meal before serving. People using the service had at least two daily choices, but could choose an alternative option on any day if they wished. Vegetarian options were also available.

We found that some people were having their food and fluid intake recorded due to being at risk of malnutrition. We found some gaps in these records where there was no record of any food or fluid intake. For example, there was a gap where there was no record of two people having had anything to eat or drink for an evening meal for a period of three consecutive days. We raised this with the provider and member of staff who told us they believed this was a recording issue.

People were offered extra helpings at the meal-time and several people accepted this. One person requested an extra sandwich and this was provided. People told us they were able to request alternatives should they not like what was on the menu. People were provided with assistance to eat and drink as required over the meal-time. There was a calm and relaxed atmosphere during the mealtimes we observed. We observed staff wearing appropriate personal protective equipment (PPE) when serving meals.

We saw a notice on the dining room door asking for peoples' privacy to be maintained when eating meals. Fresh fruit was also available and snacks and drinks were served in between meals. There was a wait of approximately 25 minutes between people being seated in the dining room and receiving their meal at lunch time, although no-one expressed any unhappiness about this.

We saw there were some adaptions to the environment, which included pictorial signs on the doors and contrasting coloured grab rails in the bathrooms which would assist people living with a dementia. There were three small lounges in which people looked comfortable and relaxed and which included a variety of different seating types. We saw in one small lounge there was a person sat with a newspaper and the remote control for the TV so they could put the TV channel of their choice on. In another lounge one person was quietly resting alone, which was their wish as identified in their care plan.

People told us they always found the home to be clean and well kept. There were assisted bathrooms with equipment to aid people with mobility problems such as a 'rise and fall' bath. There was a walk-in shower room that was beneficial for people who did not wish to use the bath and who had limited mobility. This room was warm and contained lots of freshly laundered towels, creating a welcoming environment.

There was a large enclosed and secure garden area to the rear of the premises and a residents' smoking shelter had been provided. There was a dedicated hair salon and we saw three people were enjoying using this facility on the day of the inspection engaged in conversation and reading brochures.

Good

Is the service caring?

Our findings

A person who used the service told us: "I love it here. The staff are lovely and nice with you." Another person said: "They (the staff) are very nice." A visitor to the service said: "It's very nice here and I've put my name down." Another visitor told us: "Everyone is very friendly. They talk to my relative and explain things when they get anxious. My relative is always well presented, tidy and wearing their own clothes." Another visitor said: "Staff are respectful. Here everyone seems calm and looked after."

We saw some people held keys for their rooms. One person told us: "I can go to my room when I want. I have a key for my room that has my room number on, which is useful so I don't forget."

People's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this. Staff told us they involved families when developing care plans or carrying out assessments. The people we spoke with living at the home and visitors to the service confirmed this was the case.

Staff were aware of how to ensure people's privacy and dignity was respected. For example, one staff member told us they would knock on people's doors before entering and would ensure people were covered when providing personal care. People we spoke with confirmed that they felt staff respected their privacy and dignity. A staff member said,: "The best thing about working here is the residents; listening to their stories and seeing them smile."

We observed people were treated with kindness and dignity during the inspection. Care staff spoke with people in a respectful manner. We saw that the care staff knocked on people's bedroom doors and waited for a response before entering. For example, we saw a member of staff entering a person's room after knocking and being invited in. The care staff said: "Good morning, how are you today? Are you having your breakfast in bed or in the dining room?," to which the person responded positively. We saw that people living at the home were well groomed and nicely presented.

Throughout the course of the inspection we heard lots of laughter between staff and people and there was a positive atmosphere within the home. Staff interacted with people throughout the day and it was clear that they had a good understanding of the individual people who used the service. We observed many occasions where staff spoke privately on a one-to-one basis with people.

People's communication support needs were well documented in their care plans. These sections contained a good level of detail.

Staff told us relatives were able to visit at any time of the day, although they were discouraged from visiting over meal times. We were told however, that it was possible for families to share meals with their relative if they wished. One staff member told us a relative had joined their family member for their Christmas dinner at the home.

The home displayed a variety of inspirational pictures and quotes. For example one poster read: 'Our residents do not live in our workspace; we live in their home.' Another poster read: 'To make a difference in someone's life you don't have to be brilliant, rich, beautiful or perfect. You just have to care.' We observed that staff were following these principles throughout the inspection.

Outside one lounge there was a notice board that contained information on dignity and respect, a 'my medicines my choices' charter, details on how to make a complaint, information on DoLS/MCA and the 'statement of purpose.' A list of staff on duty was also displayed, which would help people and visitors to recognise which staff were available each day.

At the time of the inspection no person was in receipt of end of life care. Each care file had a section about advanced decisions. Where people had made an advanced decision regarding end of life care this was recorded correctly, dated and signed appropriately.

Peoples' bedroom had their picture on the door, which would assist people living with dementia to find their own room. Peoples' spiritual needs were accommodated through the regular home attendance of different faith groups.

We saw records of residents and relatives meetings where discussions had resulted in changes being made within the service. For example a meeting in October 2015 identified the proposed winter menu and amendments were made to the menu on requests of the residents and their relatives. Another meeting in July 2015 discussed what activities and outings people would like to undertake in the coming

Good

Is the service caring?

months. Records were kept of each meeting and notes were given to people and their relatives. Where people were unable to read the notes, the service read out the information to the individual concerned on a one-to one basis so they were aware of what had been discussed and agreed.

Good

Is the service responsive?

Our findings

A person who used the service told us: "We went to Blackpool, it was lovely. This place is beautiful." Another person said: "Staff allow me to do things for myself if I can." A relative said: "If there are any issues I raise it with staff and it's sorted straight away." Another person told us: "Staff will answer any of your questions and will help you."

Care files were well organised and contained care plans that covered a range of health and social care support needs. This included information on mobility support, activity preferences, people's social histories, sleep, dressing and personal preferences and getting out and about. There was also a summary of people's care and support needs at the front of the care plan, which would provide a quick and accessible overview of how staff should support each person in accordance with their needs and preferences.

Care plans were person centred and would allow staff to provide support in line with people's preferences. For example, one care plan we looked at detailed that that person liked a cup of Horlicks before bed and liked to sleep with two pillows.

People we spoke with told us they had never had to raise a complaint, but would feel comfortable doing so if required. Staff told us they would document any complaints and pass them to the registered manager.

People told us they could make choices such as when they went to bed or were supported with bathing. Staff we spoke with confirmed this was the case.

In the morning we saw a 'play your cards right' quiz taking place. A large group of people were engaged in this activity. In the afternoon, we saw a gentle exercise session taken place with a smaller group of people. People told us they had enough to do to keep them occupied during the days. People said they had taken part in activities such as music quizzes, bingo and people had also visited the local church. A person who used the service told us: "Sometimes I get very bored, I like to keep busy."

We saw there were copies of a newsletter containing information on events happening at the same time of year in recent history. Photographs of previous activities were displayed in various areas in the home. Notice boards contained information on activities on offer such as music, bingo, gentle exercise, curling, music quiz, crafts and one-to-one sessions. Activities and outing had been discussed at several residents meetings.

We spoke with the activities coordinator who had recently started in post. They told us that a local school had been invited to the home to do a concert and the local Brownie's group already visited the home. They told us that they felt rewarded by their job role and described how they used reminiscence activities to stimulate people living with a dementia such as old photographs, newspapers and postcards, old fashioned books and historical pictures.

We saw people had pre-admission assessments in place, which considered peoples' support requirements. However, the pre-admission assessments we looked at were limited in the information they contained, were not fully completed and had not always been signed by the assessor or person being assessed. One pre-admission assessment we looked at did not contain any information about mobility despite other information in the care plan stating this person had had a fall prior to moving to the home. The care plan did however contain information in respect of mobility and falls risks and this had been completed in a timely manner.

One person's care plan did not accurately reflect the support they required in relation to moving and handling. We observed one person was sat in the lounge waiting for staff to assist them to transfer to their wheelchair. One staff member told this person they were looking for another member of staff to be able to assist them. Another member of staff then entered the lounge and assisted this person to transfer alone. We looked at this persons care plan, which was unclear whether this person should be assisted using a hoist. The care plan stated they were sometimes able to transfer with the support of one staff member, however the most recent reviews of the care plan stated this person should always transfer using the hoist.

We raised this issue with the registered manager who told us this person could now transfer manually with one staff member and that they would review the care plan to ensure it accurately reflected this person's needs.

We saw that one person had a child gate across their bedroom door. We asked the manager about this who explained that this was because the person had a pet cat

Good

Is the service responsive?

and the gate was in position to stop the cat from roaming around the premises, which was the persons' wish. The person as able to open the gate at any time and it did not restrict the persons' movement.

We looked at how the service managed complaints and we found that the home had procedures in place to receive and respond to complaints. There was a complaints policy and procedure in use and this was up to date. We observed the compliments and complaints file and saw that issues were responded to in a timely manner. For example on 30 November 2015 a person had requested a no-slip mat and lighting to the outside smoking shelter. A response was provided on 02 December 2015 and an explanation was given that although the shelter did not have direct electrical supply, a small light had been provided and the shelter was placed next to a bright external wall light. The non-slip mat had been purchased and the manager had requested a new shelter from the area manager. This demonstrated that the service responded to the feedback from people who used the service and their relatives.

There was information displayed on the relatives' notice board on the process to follow if they wished to make a complaint. Relatives of people we spoke with told us they knew what action to take if they needed to make a complaint.

Good

Is the service well-led?

Our findings

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.

The manager explained how they liked to start work early on several days each week in order to attend the handover from the night shift to day shift. By doing this the manager was able to immediately understand any significant events during the evening and any issues that affected a person's care needs. Attending this meeting also enabled the manager to talk to the night staff, which enabled them to feel part of the whole staff team.

Staff said they liked working at the home. They told us they thought the home was well led and said that the registered manager was approachable and fair. Staff also told us the area manager provided good support to the home when required. Staff told us they got on and worked well together as a team and that they felt valued by the manager. One staff member said: "The registered manager is a very good manager, not bossy." Another staff member told us: "I would move in (to the home)."

A person who used the service said: "The boss is lovely." Another person told us: "If I was to give it a score (the home), I would give it ten out of ten." People living at the home told us they knew the registered manager and had chatted with her regularly. We saw this happening on many occasions throughout the inspection and it was clear the manager had a detailed understanding of each individual person.

There was a full range of policies and procedures in place which were available in paper copy format and electronically. These covered all areas of care provision as well as providing specific guidance and safe systems of working in relation to use of equipment. The area manager told us that if there were any changes to policies, these would be altered by the area manager who would disseminate this information.

We reviewed documents, which the service used to monitor the quality of its service by seeking feedback from people who used the service, their families, staff and visitors. We found that residents' meetings had been held regularly. Records of these meetings were detailed and showed that various issues had been discussed. Names of people who attended and thosewho were unable to attend were also recorded and the notes of the meetings were given to those people and their families who were unable or did not want to attend the scheduled meetings. This meant that the culture within the home was open and transparent.

The service undertook a range of audits, which were competed according to different schedules and these included housekeeping, mealtimes, night visit audits, medicines, workplace safety, the kitchen, people's social needs, general building maintenance, nurse call-bells, fire and evacuation, infection control, health and safety and people's care files. A record of these audits was kept and were signed and dated. The manager also carried out a daily walk-around of the entire premises. Additional audits were carried out regularly by the area manager and covered areas such as staff files, development and training, residents meetings, the meal time experience, care files including quality of information, CQC notifications and safeguarding. We saw that an annual satisfaction survey had recently been distributed to people and their relatives, but the responses had not yet been returned.

We saw that there were audits of care plans in the front of some of the care files we looked at, and a tracker list displayed in one of the offices. Observations of medicines administration had also been regularly carried out, which staff verified.

There were a variety of cleaning schedules in place including a cooks cleaning schedule, a deep clean of a vacated room protocol and schedule, a bedroom cleaning schedule, a morning/afternoon/evening domestic cleaning schedule, a weekend cleaning schedule, a schedule for the maintenance person and a monthly evaluation of kitchen practices.

There was a business continuity plan which had been updated in October 2015 and included information of what action to take as a result of an unforeseen event such as loss of utilities supply, adverse weather conditions, fire and flood. The plan included contact numbers for relevant persons and suppliers and a 'recovery action plan

Good

Is the service well-led?

There was evidence in minutes of team meetings that findings from audits were communicated to staff and actions taken. Records of staff competency assessments via observation were also available and these included individual feedback to staff on their performance.

Accident and incident forms were completed correctly and included the action taken to resolve the issue and the corresponding statutory notification form required to be sent to CQC, where appropriate. The service appropriately submitted Statutory Notifications to the Care Quality Commission (CQC) as required and had notified the CQC of all significant events, which had occurred in line with their legal responsibilities.

We saw that a meeting had been arranged for 19 January 2016 with the Wigan Care Home Friends and Family Network, which had been arranged in partnership with the local authority.

The service worked effectively in partnership with the local authority contracts monitoring team.