GCH (Kent) Ltd

Baugh House

Inspection report

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Website: www.goldcarehomes.com

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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 Baugh House on 16 May 2016 and the inspection was unannounced. Baugh House is a care home with nursing providing accommodation and personal care for up to 60 older people including people with dementia. On the day of our visit there were 59 people living in the home. The premises are in the form of a large two-storeyed home with lifts to all floors, with nursing staff and facilities on all floors as well as ordinary domestic facilities.

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.

At the last inspection on 8 October 2014 we found the provider was not meeting the regulations in relation to carrying out quality assurance checks, the training and supervision of care staff and maintaining appropriate information on staff recruitment background checks. We asked the provider to submit an action plan detailing the improvements to be made.

These actions have been completed and on this inspection we found that the relevant requirements were being met.

People's feedback about the safety of the service described it as good and that they felt safe. People were safe because the service had provided training to staff and had systems in place to protect them from bullying, harassment, avoidable harm and potential abuse.

Staff protected people's dignity and rights through their interaction with people and by following the policies and procedures of the service Feedback from people and their relatives was that staff were caring in their attitude and responsive to people's needs. A caring attitude was observed during the inspection and personalised care, dignity and respect formed part of staff training.

Staff training and supervision had improved since the previous inspection. There was a structure and system in place for regular staff supervision and each member of staff had a training record which was relevant to their role.

The service managed the control and prevention of infection well. Staff followed correct policies and procedures and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene. Medicines were well managed, with staff displaying a sound understanding of the medicines administration systems, recording and auditing systems.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by the manager and acted on appropriately.

People at risk of poor nutrition and dehydration were sufficiently monitored and encouraged to eat and drink. The quality of the food was good, with people getting the support they needed and the choice that they liked.

Care, treatment and support plans were seen as fundamental to providing good person centred care. Care planning was focussed upon the person's whole life, including their goals, skills, abilities and how they prefer to manage their health.

The service protected people from the risks of social isolation and loneliness and recognised the importance of social contact and companionship. The service enabled people to carry out person-centred activities within the service or in the community and encouraged them to maintain hobbies and interests.

This was supported by policies and procedures which emphasised the rights of people and developments in care planning which included people's life histories written from their own perspective, which enabled staff to work in a person-centred way.

People described the responsiveness of the service as good. People received personalised care, treatment and support and were involved in identifying their needs, choices and preferences and how they are met. People's care, treatment and support was set out in a written plan that described what staff needed to do to make sure personalised care was provided.

Improvements had been made to quality assurance systems to ensure that people's views were sought and that quality audits take account of the experience of people living at the home. People described the registered manager and her team as having a positive impact on the management of the service. People were also positive about the way activities were coordinated, saying that they demonstrated an understanding of people's abilities based on consultation with people and their relatives.
Records and personal information were kept in a secure and confidential manner.

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 bullying, harassment, avoidable harm and abuse that may breach their human rights. Staff had received appropriate training in safeguarding people and were knowledgeable about how to report any concerns.

Risks to individuals and the service were managed so that people were protected whilst maintaining their autonomy and freedom. They were reviewed to ensure people could lead meaningful lives whilst keeping them as safe as possible.

The service ensured that there were sufficient numbers of suitable staff to keep people safe and meet their needs, with planned staff rotas and clear descriptions of staff duties each day.

People's medicines were managed so that they received them safely. Staff were trained in the handling, management and administration of medicines.

Is the service effective?

Good

The service was effective. People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Staff received support and training which enabled them to care and support people effectively.

People's consent to care and treatment was always sought in line with legislation and guidance. Decisions made on behalf of people that did not have the capacity to consent were made in their best interests. Staff showed a good understanding of the Mental capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People were supported to eat and drink enough and maintain a balanced diet. People's individual support needs were taken into account and their preferences were respected and menus planned in advance.

People were supported to maintain good health, have access to

healthcare services and receive ongoing healthcare support, which was provided by both community and specialist services, where required

Is the service caring?

Good

The service was caring. People were supported by staff who had developed positive caring relationships with them and who supported them maintain their connections with families through flexible visiting hours and involvement of relatives in discussions about people's care.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support.

People's privacy and dignity respected and promoted through staff ensuring that people had personal space, that their rooms were personalised and their belongings looked after securely.

Is the service responsive?

Good

The service was responsive. People received personalised care which was responsive to their needs. People were supported to have care plans that reflected how they would like to receive their care, treatment and support. These included their personal history and individual preferences.

People had control over their lives and were supported to follow a range of interests according to their preference.

The service used a variety of approaches to listen and learn from people's experiences, concerns and complaints. These included engaging with relatives, using feedback collected through external assessors and through information shared at staff handover sessions.

Policies and procedures were in place to listen to and respond to people's concerns and complaints.

Is the service well-led?

Good

The service was well-led. The registered manager had developed a culture which promoted openness and transparency for staff and a person-centred and inclusive environment for people who lived in the home.

The provider had improved on the use of quality audits and how to use these to monitor the service.

Records were held in a secure and confidential manner.	

Baugh House

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.

The inspection took place on 16 May 2016 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor in nursing care and an expert by experience who was experienced in care for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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.

We reviewed the information we held on the service including previous reports, notifications and feedback from the public. During the inspection we observed care practice and tracked the care provided through looking at records, care plans and speaking to a variety of people.

We spoke with 10 people and eight relatives. We also spoke with the registered manager, two deputy managers and activities co-ordinator. We spoke with six care staff, one registered nurse and two catering staff, including the chef. We looked at 10 care records and four staff records and reviewed the medication administration, storage and management of Controlled Drugs. We also looked at the policies and procedures of the home.

Good

Is the service safe?

Our findings

At the previous inspection in October 2014 we had found that the provider was not meeting regulations in respect of maintaining some recruitment information about staff background checks such as criminal record checks and ensuring two references were available when staff were recruited. We had asked the provider to send us an action plan setting out the improvements that would be made.

The action plan outlined how the home would ensure that staff had received appropriate checks. During the inspection of 16 May 2016 staff files all showed evidence of criminal checks through the Disclosure and Barring Service (DBS), photo ID, application form and previous employment history. References had been followed up. We saw health declarations, signed job descriptions and contracts. There were policies and procedures in place relating to staff and their work and conduct.

People told us they felt safe in the home, and relatives felt the same way. One person said, "Yes they make the residents feel special, like it is their home." Another told us, "It is safer here than being at home."

During our visit we saw that staff observed safe working practices with regard to moving and handling, ensuring there were no hazards in the home and in administering medicines.

Staff told us, and training records confirmed that they had received safeguarding training. Staff were able to describe different types of abuse and how they would report any abuse/allegation/safeguarding concern to the manager. There were no current safeguarding matters relating to the home.

There were policies and procedures in the home with regard to safeguarding. Advice and company policy regarding safeguarding people from abuse or neglect was also contained in the staff handbook which was provided to all staff. Staff we spoke with had good safeguarding knowledge, knew how to recognise abuse and how to report concerns internally and externally

Risks to people's safety were managed well so that people were protected and their freedom supported and respected. Staff had received training on how to assess risks and we saw that people's care plans included risk assessments. These included risks associated with falls, nutrition, weight loss and use of the emergency call system. Where it was appropriate to people's needs, risk assessments included the Waterlow and Malnutrition Universal Screening Tool (MUST) assessments.

Other risk assessments included moving and handling, continence, social and psychological care, communication, pain management, nutrition, general physical care and tissue viability. There were consent forms for bedrails, personal care and end of life wishes.

Accidents and incidents were recorded and appropriately signed by the nurse on duty in accordance with the procedures. The Care Quality Commission (CQC) had received notifications of accidents in the home, in accordance with the requirements of regulations.

People with dementia were cared for in a safe manner. When people behaved in a way that may challenge others, staff managed the situation in a positive way and protected people's dignity and rights. For example, people were supported to walk where they pleased, to hold on to items that made them feel comfortable, and were gently encouraged to complete their meals. These approaches meant that they reduced the causes of behaviour that distressed people. Restraint was not practised.

The premises were clean and well maintained and equipment and hoists were clean. The home kept a record of maintenance checks and any small repairs to equipment and there were up to date maintenance and audit logs of major items such as lifts and specialised beds.

People told us they thought staffing levels in the home were good. The staffing levels in the home were sufficient to meet the needs of people and ensure their safety. The nursing floor had a designated nurse in charge with up to seven care assistants throughout the day and a nurse plus three care staff at night. The residential floor had six care staff throughout the day and three care staff at night. In addition there were staff responsible for activities, domestic work, maintenance and catering which ensured care staff were not taken away from their care role.

Medicines were managed and stored safely. A dossett-style medicines administration system was used. Controlled drugs were stored correctly, and records accurately kept. As required medicines were available and they were used following the good practice guidelines.

The service managed the control and prevention of infection appropriately. Staff followed policies and procedures and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene.

Good

Is the service effective?

Our findings

At the previous inspection in October 2014 we had found that training records showed gaps in the provision of refresher training in respect of areas such as; dementia care, basic food hygiene, infection control. Staff supervision and appraisal was not being done in line with the provider's policy. We had asked the provider to send us an action plan setting out the improvements that would be made. The action plan outlined that all staff were updating the mandatory training requirements and that an annual appraisal system was implemented.

During the inspection of 16 May 2016 we saw evidence that this had been implemented and was working and that the standard was met. In addition, staff feedback was positive regarding the training and support they received in the course of their work. New staff completed their induction within 12 weeks and covered the Skills for Care Common Induction standards and staff were encouraged to participate in further training which would provide them with a qualification. The registered manager had been in place for five months and had put in place a training matrix which set out the dates when training had taken place and when these needed to be refreshed.

One care staff we spoke with described how training was provided in a mixed variety of ways, including through the use of e-learning, videos as well as working in groups. They felt this was a good balance. They knew they had training records kept and that mandatory training should be renewed regularly. They were clear that this covered the physical and psychological needs of people.

Another staff member described how their training included Continence, Dementia Awareness, Mental Capacity Act and DOLs as well as Health and Safety, Fire and Moving and Handling.

Supervision and appraisal was conducted through the nurses in charge of each area for their team. Records of supervision were held securely. One member of the care staff team told us that during the four years they had been at the home there had been lots of changes, but the ones now seemed to be the most positive. They described how they were supported through supervision and had been offered the chance to undertake NVQ training.

Relative feedback about the effectiveness of the service was positive. One relative told us, "The staff are well knowledgeable. They are aware of my wife's dietary needs as my wife can't always eat what is on the menu and they make allowances for that."

We saw that people signed decision specific consent forms, for example, for consent to have protective bedrails, as well as consent and wishes with regard to resuscitation and end of life care.

Staff understood and had a good working knowledge of the Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005. They put these into practice effectively, and ensure that people's human and legal rights are respected.

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 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.

During our inspection we saw records of applications and authorisations under DoLS. 50 people in the home were either subject to authorisation under DoLS or had had applications for authorisation made for them.

People were supported to eat and drink enough and maintain a balanced diet and people were happy with the quality of the food and the flexibility of mealtimes to suit them. On the various floors where people had lunch we observed staff attending to people and supporting them in a professional manner, and the atmosphere was pleasant and relaxed. Portions were suited to the wishes of people and there was easy access to drinks.

The chef was actively involved in ensuring that a varied and balanced menu was provided which took into account people's preferences and support needs. The chef spoke enthusiastically and positively about his role and displayed a good understanding of people's dietary needs.

People who required special assistance with eating, or who required specialist preparations of food were supported in a friendly and caring manner. People who did not wish either of the choices on the menu were able to request something else. The food was served hot and presented in a way that was appealing.

People were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support. People were positive about their access to healthcare services and their ongoing health support, which included speech and language therapy, chiropody and physiotherapy.

The service engaged proactively with health and social care agencies and acted on their recommendations and guidance in people's best interests. Appropriate referrals were made to other health and social care services, for example care managers, tissue viability nurses, community psychiatric nurses and dentists.

Premises were suitable for people and access to different floors was available by elevator. Each resident had a room with modern fittings and an en-suite toilet/washbasin. All rooms had call bells which were within reach of beds/chairs. Some rooms were personalised with photos/pictures/items of furniture. Bathrooms and toilets had suitable fittings and equipment for those with limited mobility and emergency cord pulls were accessible. There were communal lounges and dining rooms which were spacious and easily accessible for wheelchairs/other mobility aids.

Good

Is the service caring?

Our findings

People and their relatives were positive about the caring attitude of the staff. People received care and support from staff who knew and understood their history, likes, preferences and needs. The relationships between staff and people receiving support demonstrated dignity and respect at all times.

One person told us, "The staff are very kind." Another said, "I do like the food here and I do enjoy the activities." One relative told us, "[Name of person] was always an independent person. She can't use a knife and fork now, so staff prepare finger food so she can use her hands to feed herself as she won't allow anyone to feed her."

We saw that the staff had received training in person-centred care and that the home's policies and procedures placed importance on dignity and respect. During the inspection we observed the interaction between staff and people and saw that staff knew people well and were caring and attentive. Staff were in colour coded uniform to indicate designation and all were wearing name badges to help people know their names.

We saw the Service Users Guide, which is a booklet provided to everyone. This gave clear and practical information about the home's services, and emphasised person centred care as part of its overall ethos. Care plans and other records which referred to people used language that was clear, respectful and person centred.

People were supported to express their views and staff were skilled at giving people the information and explanations they needed and the time to make decisions. The home had an activities organiser who was actively involved in working with people to ensure that their views about the service and the events and activities it offered met people's interests and needs.

People were satisfied that they were treated with dignity and with respect for their wishes. One relative told us, "Oh yes, very satisfied. They don't let me in her room when doing personal hygiene and washing. They wash her hair and also do her nails. It is like a big family here and I like that."

We observed that staff were caring, knew people's names and spoke with people in a friendly and respectful manner. Staff knocked on people's doors prior to entering their rooms and waited for a response before entering. People were not rushed when being assisted to move from bed to chair/ taken to toilets. Staff answered call bells/calls for attention promptly. We saw that people's rooms had their own pictures and furniture in rooms.

In the communal areas there were always staff, as well as staff and cleaners moving around the hallways checking on the bedbound residents in their rooms and those that were not. We observed one incident where someone had spilled their tea. The care staff responded immediately and assisted the person by helping them return to their room, change their clothing and return to the lounge. For the individual concerned this meant that their dignity was respected and maintained by having sensitive and caring

support and fresh dry clothing.

In another incident, a person was clearly agitated at the arrival of a visiting relative. The activities coordinator intervened by calming the person but also placing a supportive arm around the relative and moved them both to a more private area where the mother was less agitated. This was an effective and caring intervention that demonstrated a respect for people's privacy and dignity.

Care plans and records and daily reports referred to people in respectful language. Policies inspected included policies on people's rights, dignity and privacy and confidentiality. Person centred care was part of the home's overall training programme as was dementia. Care plans included sections on end of life preferences and wishes.

Good

Is the service responsive?

Our findings

People received personalised care which met their needs.

One person told us, "It's lovely here, I have everything I need." Another person said "I am very happy. They always get the paper I like to read" A relative told us, "They are very good here. We are very satisfied with the way they are looking after [the person]." Another relative told us, "I am happy with the care he is receiving." A relative said, "My [relative] is at the stage she does not understand or participate. But they are always trying, they don't leave her. She taps her hands and feet to music."

Staff understood what was meant by and how to deliver person centred care. One staff member told us, "People are well looked after here. We always give them a choice and give them what they want." Another staff member told us, "We don't restrict them in any way or force them to do anything they don't want to do. We give them a choice and respect their individual wishes."

The care planning process was comprehensive and consistent. The was evidence of people's and/or their relatives involvement in people's care files. One person who was part of a couple living in the home told us, "We were very involved in planning our care."

Pre-admission assessments were conducted. These were comprehensive and covered people's medical history, medication, personal care needs, continence, eating and drinking, sight, hearing, communication, mobility, pain, sleep, cultural and religious needs and personal safety. The pre-admission assessment also determined the number of staff required to meet a person's needs. People had personalised evacuation plans which took account of their mobility and other needs.

Care plans had detailed information the person's life history, close relationships, important dates such as relatives' birthday, their favourite author and songs. People and/or their relatives had signed consent to care forms. There was also a form which detailed people's preferences in relation to preferred rising time, hairstyle, dress, hot drink, breakfast, music and newspaper. There were details of which people got on well with each other. This information was used to sit people together at breakfast and lunch times.

Staff knew people well and were able to describe about people's personal histories and preferences. They also knew what made people happy and what triggered challenging behaviour. A staff member told me, "I haven't been here long but I got to know people quickly by looking at their care plans, talking to them and talking to staff." Staff were required to do hourly checks on people who did not leave their room. At the time of inspection we observed five residents in the palliative stage of their dementia who were nursed in bed, and had regular, recorded nurse care visits. Over the two floors there were 17 people who were mainly bedfast. We saw that staff regularly checked to ensure they were comfortable.

People's care files were kept in a locked room only accessible by staff. The files were well organised and up to date. There was evidence that people's care plans were reviewed monthly. DNAR forms were properly completed and where the person was unable to participate in the decision, there was evidence that a best

interest meeting had been held.

People's rooms were personalised with pictures and ornaments. In some cases people's rooms had their own furniture. People were dressed in clothes of their choice. One person was dressed in a tracksuit and a relative confirmed that the person had been a fitness fanatic before dementia set in and that this was their preferred attire. Another person was wearing a white summer floppy hat. A staff member told us it was the person's favourite hat.

Care plans had detailed instructions on how to deliver person-centred care and support people to be as independent as they were able to be. For example, one recorded entry stated "It is important to [the person] to be neatly presented. [The person] would like staff to help them maintain their ability to care for themselves as much as possible." This was followed by instructions on how to do so.

People had their preferred breakfast at a time that suited them. Some people had a full English, some tea and toast, others cereal. There were dedicated staff for assisting people in the dining room and assisting people who chose to stay in their own room. This meant that staff could respond to people's needs without causing delays.

People had risk assessments which were reviewed monthly and considered relevant risks. There were individual care plans for areas where risks were identified (such as a high risk of falls) which gave staff information on how to manage the risk.

We saw evidence that a variety of external healthcare professionals were involved in people's care such as Chiropodists and GP. Care files also contained accident/ incident reports which detailed information such as incidents of falls. This information was monitored and triggered a care plan review and/or referral to external healthcare professionals. We saw that where a person had had fallen they were observed hourly for the first 12 Hours and then 12 hourly for the next 60 hrs. Malnutrition Universal Screening Tool (MUST) assessments were carried out. People were weighed monthly and the information recorded consistently. Where appropriate their care plan was reviewed.

Visitors were arriving throughout the day and were welcomed by staff. One told me, "I visit about three times per week. I live locally and pop in at any time." Another told me, "I visit every day." Visitors appeared comfortable and I saw friendly communication between visitors and staff. We saw visitors making themselves and their relatives cups of tea. Visitors had ready access to all the communal areas of the home including the garden.

The home was able to respond to special occasions such as birthdays by arranging for the person and their guests to dine separately in a comfortable dining area. This room was also used by the "Resident of the Day". The idea of this was that each resident would have a day when they would be pampered by staff and made to feel special. They would also have their meals in this rooms and their preferred selection of music playing.

The service employed three activity co-ordinators. There was an activities schedule which was displayed on noticeboards in the communal areas. People and their relatives gave their views on the activities they would like during the pre-admission assessment, during informal feedback and at relatives' meetings. The activity co-ordinator based on the dementia floor told us, "I use information form their personal histories and from pictures in their rooms, as well as speaking to their families to get to know them and what they like to spend their time doing."

Everyone we spoke with was complimentary about the activities coordinators and the deputy managers who were responsive to people's wishes, views and suggestions by ensuring that ideas were taken forward, changes in need were recorded in updated care plans or by preparing activities that people enjoyed.

The activities available included live entertainment once per week such as tribute shows from 1940s, bingo, karaoke and day trips. One person told us, "We recently went on a trip to a farm and quite enjoyed it." Another person told us, "I don't go out much but if I wanted to the staff would support me to." The activities co-ordinator regularly brought in her dog as many of the residents enjoyed having a pet around. There was a rummage box. People who wanted to were able to fold clothes. There were a variety of games on offer suitable for people with dementia. The co-ordinator told me, "We try to involve residents in everything we do." People who stayed in their rooms were visited to have one-to-one activities in their room, for example have their nails painted.

Relatives felt they had a say in how the service was run. We saw the minutes of relatives meetings held on 28/1/16, 3/3/16 and 7/4/16. They were well attended. The minutes demonstrated that relatives felt comfortable raising issues of concern and making suggestions to improve the service. We saw that suggestions to improve the activities on offer were acted on. The registered manager also arranged for guest speaker to inform relatives on aspects of care people were receiving, such as end of life care. Issues such as the maintenance of the home, new staff, training and any other business was also discussed. The registered manager had suggested that relatives formed a Relatives Support Group. The relatives did so and used their meetings to discuss issues they wanted to bring to the relatives meetings held at the home.

However, residents meetings were not held. One person commented, "I've never been invited to a meeting. Really everything is set up for the people who have dementia, the food and activities. I don't have dementia." We discussed this with the registered manager who told us that the meetings were in fact for both relatives and people. However, due to the small number of people who could meaningfully take part people did not often take up the opportunity to attend. It was an area that could nonetheless be explored further.

There was an established complaints system in place. We looked at the complaints file and saw that people's complaints were recorded and responded to quickly. Relatives felt able to complain and told me, "When I've not been happy with something, I spoken to the manager about it and she's done her best to sort it out." Another relative told us, "Whenever I've made a suggestion, it's always taken on board." Where a relative had complained about the attitude of an agency staff member that staff member was not allowed to work in the home again.

One relative had raised a concern in the previous six weeks about her mother not having a call buzzer nearby. We saw that this concern was actioned on the same day, and a call buzzer has been placed on her pillow since.

Good

Is the service well-led?

Our findings

People and relatives spoke positively about how the service promoted a positive culture that is person-centred, open, inclusive and empowering.

At the previous inspection in October 2014 we found that the provider did not adequately protect service users and others who may be at risk by regularly assessing and monitoring the quality of the services provided. We had asked the provider to send us an action plan setting out the improvements that would be made. The provider sent us an action plan which outlined how the quality assurance system and clinical governance system would be improved within the home.

During the inspection of 16 May 2016 we saw that improvements had been made to the quality assurance systems and that these were designed to monitor the quality of the service provided.

We saw that, in addition to technical audits of safety, maintenance and health and safety issues, the provider had implemented a quality assurance system which provided data and information which could be analysed and discussed with a view to ensuring continuous improvement. Quality audits were carried out by a manager. The information was then sent to the regional quality assurance team. This was then rated on a risk basis (Red, Amber, Green). There were also monthly visits by the regional manager.

Supervision and appraisal of staff had also improved as a result of improved quality assurance, and was not more regular. In addition, the registered manager had implemented short meetings three times per week where the senior staff provided a short feedback on the areas for which they were responsible. Regular team meetings were held, and staff told us they were positive and improved morale. One member of staff told us, ""We work well as a team. I couldn't do without them." Another said, "I really enjoy working here. Everybody is fantastic. I can ask anybody if I'm unsure about anything."

The registered manager, together with the deputies placed a strong emphasis on ensuring a high staff morale in order that this would produce effective person-centred care. For example, there was a "staff of the month" award. Staff told us they felt listened to. However, one area of confusion was over whether staff were able to have meals with people who used the service. Staff were unanimous in their view that it was company policy that they had to pay for any meal, such as lunch and that staff ate their meals in the staff room. The registered manager was of the view that this was an out of date policy.

The question arose out of the idea that mealtimes were a natural occasion where staff and people could interact socially, where staff could identify any issues from people that may require acting on and where an atmosphere of friendship and mutual understanding could develop. The manager agreed to explore this issue and to clarify the official company policy on staff payment of meals and eating with people.

Further quality checks were carried out at night once every three months by a manager and a report made out as to the findings.

The service demonstrated good management and leadership. Improvements to the staffing structure meant that staff had a named person for supervision, roles were clearly defined and there was a structure that allowed staff to understand their roles and responsibilities clearly. The registered manager and deputies were ably supported by an administration officer within the home and a business manager who operated at regional level but who visited the home regularly.

The registered manager understood her responsibilities and CQC registration requirements and management audits were developed to reflect the fundamental standards as described by CQC. The registered manager maintained strong links with professional bodies such as health services, social services and mental health services, as well as services which specialised in palliative care.

Since the time the registered manager has been in place she has had a strong visible presence in the home and this was positively commented on by people and relatives.

We saw that records were maintained and held securely.