Croftwood Care UK Limited

Thorley House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an inspection of Thorley House Residential Care Home on the 14 and 15 November 2018, the first day of inspection was unannounced. This was the first time the home had been inspected since it re-registered with the Care Quality Commission in November 2017, due to a change in ownership.

Thorley House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Thorley House Residential Care Home is situated in a quiet residential area of Hindley, Wigan and is registered to provide personal care and accommodation for 40 people. At the time of this inspection 40 people were living at the home.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home had a clear management structure in place. The registered manager was supported by a deputy manager, as well as the area manager, who used to run the home, so was familiar with the people and staff. People, their relatives and staff spoke positively about the running of the home, telling us both managers were approachable, willing to 'muck in' and they had a visible presence throughout the home.

People told us they felt safe living at Thorley House and thought there were enough staff to provide safe care and respond to their requests for support. Relatives were also complimentary, reporting their family members were well cared for and their needs met. Both people and relatives told us they would feel comfortable approaching a staff member or the registered manager should they have any concerns or complaints, but had not yet had cause to.

The home had appropriate safeguarding policies and reporting procedures in place and had submitted notifications to the local authority and CQC as required. Staff had all received training in safeguarding, which was regularly refreshed. Staff were aware of the different types of abuse and how to report concerns.

The home had effective infection control and cleaning procedures in place. Regular monitoring of the environment was completed and checklists used to ensure cleaning tasks had been completed to required standards. Staff wore personal protective equipment (PPE) to prevent the spread of infection and toilets and bathrooms contained hand hygiene equipment and guidance.

Medicines were stored, handled and administered safely and effectively. Documentation had been completed correctly and consistently. All medicines checked had been administered as prescribed. Staff

responsible for administering medicines had been trained and had their competency assessed. Audits were completed weekly and monthly to ensure standards had been maintained and that any shortfalls or issues were addressed.

We found care files contained detailed risk assessments, which had been regularly reviewed to reflect people's changing needs. This ensured staff had the necessary information to help minimise risks to people living at the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. All staff members we spoke with demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We saw the service was working within the principles of the MCA and had followed the correct procedures when making DoLS applications.

Staff spoke positively about the support and training provided. Staff completed an induction training programme upon commencing employment and on-going training was provided, both e-learning and face to face, to ensure skills and knowledge remained up to date. Supervision was completed to provide staff with an opportunity to discuss their roles, any areas for improvement and future goals.

People were happy with the choice of meals provided and told us they received enough to eat and drink. People were involved in decision making around what they ate, with menus discussed at resident meetings and changes made following feedback. Special dietary requirements were catered for, such as soft meals or thickened fluids. Food and fluid charts had been used where people had specific nutritional or hydration needs, with clear guidance in place for staff to follow.

People told us staff were kind, caring and treated them with dignity and respect. Staff had taken time to get to know people, which was evident in the interactions we observed. People were comfortable in the company of staff members and engaged in friendly conversation and 'banter', laughing and joking as they received support.

Care files contained personalised information about the people who used the service and how they wished to be supported and cared for. Each file contained concise, yet informative care plans and risk assessments, which helped ensure people's needs were being met and their safety maintained. People and their relatives told us they were involved in care planning and reviews.

Peoples' social and recreational needs were met through an activities programme, facilitated by an enthusiastic co-ordinator. We saw a mix of activities were organised throughout the week which catered for all interests and abilities along with regular outings and visits from entertainers.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily, weekly, monthly or quarterly basis, depending on the area being assessed and covered a wide range of areas including medication, meal times, infection control, accidents and incidents and health and safety. Provider level audits had also been completed on a monthly basis, to provide further oversight of all aspects of service provision.

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 we spoke with told us they felt safe living at Thorley House. Staff were trained in safeguarding procedures and knew how to report concerns.

Staffing levels were appropriate to meet people's needs and keep them safe.

Medicines were stored, handled and administered safely by trained staff that had their competency assessed regularly.

Is the service effective?

Good

The service was effective.

The service was meeting the requirements of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS).

Staff reported sufficient and regular training and supervision was provided to enable them to carry out their roles successfully.

The dining experience was positive and we saw nutritional needs were being assessed and provided as per professional recommendations.

Is the service caring?

Good

The service was caring.

People living at the home were positive about the care and support provided, telling us that staff were kind, respectful and treated them with dignity.

Staff had a good understanding of the people they cared for and were mindful of the importance of promoting people's independence.

People's preferences were captured within care files and care was provided in line with their wishes.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person-centred way.

The home had an activities programme in place. People we spoke with were positive about the activities and outings available.

People's wishes at the end of their life had been captured and the home ensured these were provided as requested

Is the service well-led?

Good

The service was well-led.

Both the people living at the home and staff working there said the home was well-led and managed and that they felt supported by both the registered and deputy managers.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, with action points generated and details of progress clearly documented.

The home encouraged and promoted links with the local community and voluntary groups, to benefit people living at the home and develop social inclusion.

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.

The inspection took place on the 14 and 15 November 2018. The first day of the inspection was unannounced.

The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC). An Inspection Manager from the CQC also attended on the first day and returned to witness feedback on the second day. This was to observe the inspection as part of CQC's governance procedures.

Before commencing the inspection, we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. We also contacted the quality assurance team at Wigan Council to ask for their views of the home and any other information to assist the planning and inspection process. Feedback provided was positive, with no concerns noted.

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.

During the course of the inspection we spoke with the registered manager, deputy manager and six staff members. We also spoke with five people who lived at the home, two relatives and a visiting professional.

We looked around the home and viewed a variety of documentation and records. This included; five staff files, five care files, seven Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

Good

Is the service safe?

Our findings

People living at the home told us they felt safe. Relatives we spoke with confirmed their family members received safe care which met their needs. Comments included, "Yes, I feel safe 100%", "Yes, it's a safe place to live, there's no worries there" and "Yes, mum's safe here. No concerns with the care provided."

The home had effective safeguarding policies and procedures in place. Staff told us they had received training in safeguarding, which was refreshed annually and all knew how to identify the different types of abuse and report any concerns. One staff member told us, "I would report to the care team leader or [registered manager], I feel comfortable going to either them." Another stated, "I have been on the tier training run by local authority, so know about these and how to report tier one and tier two safeguarding concerns. I would tell [registered manager] about any concerns."

The home had a safeguarding file in place, which contained a copy of the local authority reporting guidance. We saw all incidents had been reported in line with guidance.

We found safe recruitment practices had been followed. We looked at five personnel files, which all contained an application form, proof of identity and at least two references, along with Disclosure and Barring Service (DBS) check information. A DBS is undertaken to help determine that staff are of suitable character to work with vulnerable people. Existing staff had also signed an annual declaration, to confirm they had not received any cautions or convictions within the last 12 months, as these could affect their suitability for continued employment.

Enough staff had been deployed to safely meet people's needs. People and relatives told us staff responded to their requests for support quickly, however did feel the staff 'worked hard' and were 'very busy' and more staff would make their job easier. Staffing levels had been determined using a system, which is sometimes called a 'dependency tool'. The tool calculated the number of care hours which needed to be provided each week based on people's level of dependency, i.e. how much support they required. We saw staffing hours provided per week, exceeded the number of care hours the dependency tool indicated was required. We looked at rotas for four weeks prior to the inspection which confirmed staffing levels deployed were sufficient to meet people's needs.

Accidents and incidents had been recorded consistently and managed appropriately. Monthly logs had been completed which captured the number of accidents, time of day they occurred, injuries sustained and type of treatment required, in order to look for trends and minimise future risks. Post-accident or falls observations had been carried out for up to 72 hours, to ensure the person was safe and well. Weekly falls monitoring had also been completed, which included the action taken to reduce risks and help prevent a re-occurrence. For people who had experienced frequent falls, we noted a referral had been made to the local authority's falls team for assessment.

The home was clean and free from odours with robust infection control and cleaning processes in place. Bathrooms and toilets contained hand washing guidance, along with liquid soap and paper towels. Staff

had access to and used personal protective equipment (PPE) such as gloves and aprons, to minimise the spread of infection. People and relatives also commented on the cleanliness of the home, one told us, "The home is spotless. There are no smells, you can go in some homes and it hits you, but not here."

The home had effective systems in place to ensure the premises and equipment were safe and fit for purpose. Safety certificates were in place and up to date for both gas and electricity, hoists, the lift and fire equipment, which had all been serviced as per guidance with records evidencing this. Call points, emergency lighting, fire doors and fire extinguishers were all checked regularly to ensure they were in working order. There was an up to date fire risk assessment in place, along with personal emergency evacuation plans (PEEPs). The PEEP detailed the escape routes and identified the people who will assist in carrying out the evacuation.

Medicines were being managed safely. As part of the inspection we looked at the home's management of medicines, which included reviewing documentation, checking stock levels and ensuring staff had the necessary guidance to ensure they administered medicines safely and when people needed them. We saw staff had received training in medicines management and had their competency assessed annually.

We found medicines administration records (MARs) had been completed accurately and consistently. Each person had a cover sheet alongside their MAR which contained their name, photograph, allergies and special instructions, such as how they liked to take their medicines. An information sheet was also present which listed the medicines prescribed, an image of the medicine, dosage and administration details. This ensured staff knew each medicine a person took, what this looked like and when people should take it. Stock checks of medicines showed the amount remaining tallied with the amount received and what had been administered, . This confirmed people had received their medicines each day as prescribed.

We saw 'as required' (PRN) protocols in place for people who took this type of medicine, such as paracetamol. These provided staff with information about how much to give, when to administer and what signs to look for that would indicate the medicine may be required, in case the person couldn't tell them. This ensured medicines had been administered safely and when needed.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines had been administered and documented as per guidance.

At the time of inspection nobody required their medicines to be given covertly, which means without their knowledge. However, the home had policies and procedures in place, should this be required.

Good

Is the service effective?

Our findings

The home provided care which was personalised and responsive to people's individual needs and preferences. Pre-admission assessments had been completed for all people living at the home. These captured key information about the person including past and present medical information, areas of need and support required, which ensured staff had an understanding of the person's needs prior to moving in and assisted with the initial writing of the care plan.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

The home was acting in accordance with the MCA. Staff confirmed training had been provided in MCA and DoLS and spoke knowledgeably about both of these. Comments included, "Yes, DoLS stands for Deprivation of Liberty Safeguards, I understand what it's about, things people can and can't do, keeping them safe. MCA covers people's rights to make choices and assessing their capacity to make decisions" and "MCA is from 2005, it has five core principles. You don't assume someone lacks capacity, until proven otherwise."

People's consent was sought both upon initial admission to the home and prior to receiving care. Care files contained consent forms which covered a range of areas including provision of care and support, use of photographs, involvement in care planning and signing of these and professionals having access to records. Where people lacked capacity to consent and did not have a legal representative, such as a Lasting Power of Attorney (LPA) for health and welfare in place, we saw mental capacity assessments and best interest meetings had taken place to make important decisions.

We found DoLS applications had been submitted where required, with a log used to monitor applications. We saw outstanding assessments had been chased up periodically by the registered manager.

Staff told us they received sufficient training and support to carry out their roles. One stated, "We get lots of training, I am happy with it." Another said, "We get enough, manual handling is updated every 12 months, refreshers in lots of areas are done every year as well." A third told us, "We do a mix of online and face to face sessions, training here is good."

Training completion was monitored via a matrix, with training certificates stored in staff personnel files. We

noted staff had completed training in a number of areas relevant to their role, including MCA and DoLS, moving and handling, safeguarding, health and safety and infection control. The matrix was colour coded to indicate training was in date or required updating. Where updates were required, these had been scheduled. We also saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate, or something they can demonstrate is of equivalent standard, to staff new to working in health and social care as part of their induction.

We found the home was responsive to staff's specific needs when considering training provision. We saw training presentations had been converted into one staff members first language to make it easier for them to understand.

We saw supervision and appraisals had been scheduled and completed, however not consistently in line with the providers policy, which stated staff should receive at least four per year. This issue has been identified by internal audits and a plan was in place to address this. Staff we spoke with all told us they felt supported and were happy with the current frequency of supervision meetings.

People living at the home told us they enjoyed the food and got enough to eat and drink. Comments included, "The food is good, we can choose what we have and get enough to eat and drink", "We had a meeting about the food, and get more vegetables and salad now which I like" and "I think it's quite good [the food], I get enough to eat and drink, no complaints."

The home operated a 'marvellous mealtimes' initiative, which aimed to ensure dignity and choice was maintained. Mealtimes were audited on a quarterly basis, to ensure standards had been maintained and the mealtime period was positive for people. We observed two mealtimes during the inspection. On both occasions the dining room was full, with people sitting where they chose and engaging in conversation with their peers. Food was served straight from the kitchen via a serving hatch, which ensured it was fresh and hot. The day's menu was displayed on a chalkboard, with the weekly menu on display outside the dining area. We noted cutlery was not laid out and was told this was only brought at the time of service, to reflect the person's meal choice, for example if only having soup, they would just be provided with a spoon. People were happy with this arrangement.

People who required a modified diet, such as a soft meal or thickened fluids, received these in line with their assessed needs, with detailed guidance contained in their care files. Similarly, people who had food intolerances or allergies, had been appropriately catered for, with their choices respected. For example, one person, sometimes chose to eat foods their nutrition care plan said to avoid, however as they had capacity, their wishes had been met.

People's weights were monitored in line with their care plan, with a formal nutritional monitoring system, the Malnutrition Universal Scoring Tool (MUST), being completed monthly. We saw the home was responsive to changes in people's weights, with food and fluid charts introduced and referrals made to a dietician, when unplanned weight loss had occurred.

People's pressure care needs were being met. The home followed the React to Red pressure ulcer prevention campaign, which aims to educate as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them. The Waterlow was being completed each month, which is a formal prevention and monitoring tool, used to assess people's risk of skin breakdown. Where necessary, pressure relieving equipment was in place, which included pressure cushions and airflow mattresses. Mattress settings had been included in people's skin integrity care plans, so staff knew the

correct setting and could ensure it was maintained. At the time of the inspection, nobody living at the home had an active pressure area or required staff to provide pressure relief.

People told us their health needs were being met. Comments included, "Yes, they are very good, they get the doctor when I need one. All my medical needs are met" and "No problem with this, they sort out all my appointments." We saw one person had requested a referral to a specific medical professional, due to concerns they had. This was done promptly, with feedback following the consultation captured in the care plan, so staff could provide the correct support moving forwards.

Involvement with other professionals and agencies to meet people's health needs was recorded in people's files and included general practitioners (GP's), opticians, chiropodists, district nurses, advanced nurse practitioners (ANP's) and speech and language therapists (SaLT). We spoke with a visiting professional who told us, "All the staff are really helpful. They are on the ball and referrals are submitted timely. All my colleagues who have involvement with the home are more than happy with the care provided."

We saw some consideration had been given to ensuring the environment was 'dementia friendly'. Corridors were light and airy with plain flooring and walls, which had contrasting coloured handrails to make them easier to identify. Large pictorial signage was in place on all bathrooms and toilets and there was also a large pictorial board which informed people of the day, date, time, season and weather.

Good

Is the service caring?

Our findings

People told us they received care in line with their wishes from staff who were kind and considerate. Relatives also spoke positively about the standard of care provided. Comments included, "The staff are very kind and thoughtful", "Staff are very pleasant, I think they do a good job", "The girls are very pleasant and helpful, all the staff are lovely to be honest" and "Very much being cared for how she would like, she thinks she is in a hotel, the service is that good, can't praise the staff enough."

People were also treated with dignity and respect by the staff who supported them. One person told us, "Yes, I am treated with dignity and respected. We get privacy when needed and they make sure everyone is always clean and well dressed." A relative told us, "I remember once a staff member came in on their day off and did everyone's hair for free as the hairdresser was off. They knew people liked to look nice, which is why they did it, they did a really good job too."

Staff were mindful of the importance of preserving people's dignity and were able to describe ways in which this was achieved. Comments included, "By asking permission, treating people as individuals, not making assumptions about what they want, closing doors, not interrupting when personal care is going on" and "Ensure people have choices, privacy, ensure doors are shut and they know what you are going to do."

People we spoke with confirmed staff knew what they wanted and offered them choice. One told us, "They [staff] know me very well, they ask me what I would like to do and respect my wishes." Another said, "I chat to the staff all the time, I have known some of them for years and they know me. I get to choose how I spend my time."

Over the course of the inspection we spent time observing the care provided in all areas of the home. People praised the staff for the care and compassion they received. We saw everyone was clean, presentable and well dressed. Staff were observed to be kind, caring and patient in their interaction with people, taking time to engage in conversation and 'banter', which evidenced the relationships they had formed. We observed appropriate physical contact being provided by the staff, such as hand holding or placing their arm around someone whilst speaking with them, which resulted in smiles from the people they were supporting.

Staff were knowledgeable on the importance of promoting independence. We observed staff encouraging people to do things for themselves or providing reassurance to people, such as praising people's efforts when mobilising. One staff member told us, "We try and keep residents as mobile as possible, provide their own personal care as much as possible, support them to dress themselves. It is about being aware of people's limitations and encouraging them as much as possible."

There was a positive culture at the service and people were provided with care that was sensitive to their needs and non-discriminatory. Staff were mindful of the importance of catering for people's diverse needs, whether these be spiritual or cultural. Care files contained sections which captured people's needs, wishes, religious and cultural beliefs or requests. At the time of inspection nobody living at the home had any specific requirements, however staff told us these would be catered for. We saw representatives from both

the Catholic and Church of England faiths, visited the home regularly to provide communion and hold a monthly service. People from other faiths, including Evangelical, Methodist and Mormon had also been supported to practice their faith.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the service had met this standard. We saw people had communication care plans in place which explained any difficulties they may have and how best to communicate with them. Information was also available in regard to aids or equipment in use, such as hearing aids and glasses. Where people were reluctant to use these, this was emphasised, along with how staff should support the person as a result. Noticeboards were used to provide a wide range of information for people living at the home, with some being written in an 'easy read' format, which consisted of simple text and pictures, to make it easier for people to understand.

People were able to express their views, be involved in the running of the home and in making decisions. Resident meetings had been held bi-monthly, which covered topics such as forthcoming activities and events, menus, general home information and any other business. People's views had also been sought through annual questionnaires, with written feedback provided on the findings and actions the home intended to implement as a result.

Good

Is the service responsive?

Our findings

People had been involved in the care planning process, which was evident from the care files we looked at. Although not all could remember doing so when spoken with, we found care plans had been signed by people, where they had capacity and had consented to doing so. Monthly reviews reflected people's views and opinions and whether they were still happy with the care provided.

Relatives spoke positively about their involvement with their family member's care and the home's communication with them. One told us, "We have always been involved in the care. We picked this home as another relative had stayed here, we wouldn't have chosen anywhere else." Another said, "We are involved in the care and have seen the care plan, any problems are sorted straight away."

Each person's file contained a 'life plan', which stated at the beginning, 'My life plan will help you know who I am and what we can do together to help me enjoy a satisfying lifestyle'. We saw a range of personalised information had been captured on a 'past experiences' form including people's life history, educational and work background, hobbies and interests. This ensured staff knew what was important to each person and helped inform the care planning process.

Each file we viewed contained a range of personalised care plans which covered areas such as personal care, nutrition, mobility, communication, mental health and wellbeing. For each area covered, the care plan listed the person's needs, how they lived/coped with any difficulties, what help they wanted from staff and how staff would know this had worked. Following reviews, we noted any required changes had been made promptly.

The home had a clear complaints procedure, which was displayed on noticeboards in communal areas, as well as in the service user guide. None of the people or relatives we spoke with had raised a complaint, however all knew how to do so. Comments included, "I would speak to any of the staff, they are all helpful", "I would go to a staff member or the manager" and "Yes, I know what to do, would speak to [registered manager] though not had to."

Complaints were logged electronically, however, in line with the feedback received, we saw none had been submitted in the last 12 months.

The home had a dedicated file for storing thank you cards and messages, as well as displaying these within the home. Recent comments included, 'Thank you for all the love, respect and care you all showed mum. It was truly touching to witness the love and care you all gave' and 'I wish to give you a very big thank you for all your help.'

People and their relatives were complimentary about the activity programme provided by the home. One told us, "Yesterday they were playing floor netball, staff got everyone in the lounge involved. There's always something going on." Another stated, "We have a timetable on the wall, we do all the things written on there. We went to Ena Mill yesterday." A third said, "Plenty going on, been on a canal trip, had people coming into

the home, singers and such like. It's your choice whether you take part or not."

The home employed a co-ordinator, who was responsible for organising and facilitating activities within the home. The co-ordinator kept records of people's involvement, which was stored in their care file. We asked the co-ordinator about what activities they organised and the monthly schedule, which was displayed in the home. They told us, "We have certain things which don't move, we occasionally move bingo but try to keep it Thursday afternoon. We do quizzes, play domino's, have a knitting circle, did some baking last week, have dress up days and always decorate the home for events. We had an entertainer the other week, a trip to Blackpool illuminations. I Try and spend quiet 1:1 time with people which is logged. I am also a trained reader leader, and run a reading group. Community groups also come in, such as the Brownies and Wigan Warriors."

People's end of life wishes were being met. The home and staff prided themselves on their provision of end of life care and ensuring people's wishes had been met. We saw the home had recently responded to a person's wish for them to help plan a celebration of their life, ensuring each of the things they had asked for, from what they wore through to liaising with the undertaker had been completed. A staff member told us, "We have a good reputation, we do training in this, get a lot of support from GP and district nurses and follow their instructions."

The home had documentation in place to capture people's wishes when nearing the end of their life. These included things people wanted to have achieved before they died, their preferences before and after, help they wanted to achieve their wishes, and the people they wanted to be involved and kept informed. An additional document, listed specific instructions, special cultural or religious requirements, such as which church to use and where they wished to be buried or cremated.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

People living at the home and the relatives we spoke with, knew the manager and felt the home was well-led. They also told us they would happily recommend it to other people. Comments included, "[Registered manager] is very approachable, a very nice lady. She's down to earth, said if I ever need anything, go and see her", "[Registered manager] is good, as is the deputy, I can have a laugh with both of them" and "I know [registered manger]. I would recommend this home to anyone, I call it Butlins, it's so good."

Staff told us they enjoyed working at the home and felt supported by the registered manager and deputy manager. One said, "[Registered and deputy manager's] are very good, both are approachable and I feel supported." Another stated, "I feel supported here, I can talk to [registered manager] about anything." A third told us, "She is very good is [registered manager], will go out of her way to help, she listens a lot and is easy to talk to."

Staff meetings were being held, however there was some discrepancy as to the frequency of these. There was no clear schedule as to when meetings had been held and when talking to staff, they mentioned differing time scales of monthly, bi-monthly and quarterly. We saw minutes for two staff meetings in 2018, along with separate minutes for meetings with care team leaders and kitchen staff. All staff we spoke with confirmed more meetings than this had been held and the registered manager told us the minutes on file did not reflect completion. We discussed the benefit of having an annual schedule for staff meetings, to ensure regular completion and allow staff to make plans to attend. We will follow this up at our next inspection.

We found the home to be an inclusive and empowering environment. Both people and staff's views and opinions were sought and acted upon and they were also involved in making decisions about how the home was run. The most recent staff survey was underway at the time of the inspection, with questionnaires distributed and the home awaiting responses.

During the inspection we saw examples of partnership working. The home was involved with The Reader, a voluntary organisation which promotes shared reading to improve wellbeing and reduce social isolation. The activity coordinator was a trained leader in this and actively promoted it within the home. As mentioned in the responsive domain, the home also had links with local groups and sporting clubs, who visited the home to spend time with people and complete activities. The home opened up activities and events to local residents to encourage involvement and inclusion. We saw a thank you card from one person who had become a regular visitor to the home.

The home used a range of systems to assess the quality of the service. The area manager completed

monthly audits to assess the quality of service provision as a whole. Following each audit, the home received a rating, which was in line with CQC's ratings of inadequate, requires improvement, good and outstanding. We saw action plans had been generated following each audit, which the registered manager had addressed by the next visit.

The home completed a range of internal audits, the frequency of which varied depending on the area being assessed. Areas covered included workplace safety, cleanliness and infection control and staffing, through to care based areas such as safeguarding, accidents and incidents.. nutrition and pressure care. For each audit we saw actions and outcomes had been recorded, to ensure continuous improvement was maintained and the home was meeting regulations. The registered manager completed a daily 'walk round', which allowed them to observe care in all areas of the home, speak with people about their experiences and carry out spot checks of documentation. Each walk round had been documented with action points and feedback included.

We found accidents, incidents and safeguarding had been appropriately reported as required. The registered manager ensured statutory notifications had been completed and sent to CQC copies of all notifications submitted were kept on file.

The home's policies and procedures were stored electronically and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at provider level; which meant that the most up to date copies were always available. We spoke with staff who were able to demonstrate a good understanding of the policies which underpinned their job role such as safeguarding people, health and safety and infection control.