Davenport Manor Nursing Home Limited

Clarendon House

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

Overall summary

This inspection took place on 7 and 8 December 2015. Our visit on the 7 December was unannounced

The service was previously inspected on 11 September 2013 when no breaches of legal requirements were found.

Clarendon House is located in Bramhall near Stockport. The home is registered to provide accommodation and personal care for up to 32 people. Bedrooms are situated on the ground floor and first floor of the home. Access between floors is via a stair lift and passenger lift.

11bedrooms had an en-suite toilet. The building is situated in its own grounds with secure gardens and off road parking. At the time of our inspection 25 people were living at Clarendon House.

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.

People who used the service, who we asked, told us that Clarendon House was a safe place to live and felt they were looked after well.

Staff we spoke with understood their role in making sure they safeguarded vulnerable people from harm and had undertaken training in adult safeguarding.

Care plans clearly detailed the areas of support people needed and included associated risk assessments.

People who lived at Clarendon House were supported to live as independently as possible by sufficient numbers of suitably trained staff, who had been appropriately and safely recruited to support and meet people's individual needs.

Care staff who we spoke with had all received a thorough induction, training and support when they started work at the home and understood their roles and responsibilities, as well as the values and philosophy of the home.

Staff had a clear understanding of the care and support people required and knew how to make sure the care provided met people's assessed care needs as detailed in the care plans and we saw that people were supported to eat and drink enough to maintain a balanced diet.

The staff training record showed staff had access to a range of appropriate training such as dementia awareness and end of life care and the staff we spoke with confirmed this. They also told us that they felt well supported by the manager and found the management team to be approachable.

Records showed that people had consented to the care and treatment before it was provided. People who we spoke with told us that the staff were caring and we observed good relationships between individual staff and people who used the service.

We saw that care was provided with kindness; staff were respectful when speaking with people and responded promptly when people required assistance. People we saw looked well cared for and comfortable in their surroundings.

People told us they knew who to speak to if they wanted to raise a concern or complaint. A copy of the complaints process was displayed in prominent areas throughout the home. This promoted a positive culture that was open, inclusive and empowering.

To help make sure that people received safe and effective care, systems had been put in place to monitor the quality of service being provided. These systems included regular checks on all aspects of the management of the service.

We saw that the cleaning system in place helped to make sure the home was clean and any offensive odours apparent during our visit were attended to immediately.

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's medicines were available in the necessary quantities at the prescribed times to prevent the risks associated with medicines that are not administered as prescribed.

People were supported by sufficient numbers of suitably trained staff, who had been safely recruited and were available at all times to support and meet people's individual needs.

Risk assessments were in place to help protect people using the service and the staff. People lived and worked in a safe, well maintained and secure environment.

Good

Is the service effective?
The service was effective.

Care staff had all received induction training and support when they started work at the service and understood their roles and responsibilities. There was a staff supervision plan in place which was being followed to make sure staff were continually supported in their work.

Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) authorisations were in place for people. Staff had received training in the MCA; this legislation is designed to protect people who may be unable to make their own decisions.

Good

Is the service caring?
The service was caring.

Staff spoken with were knowledgeable about people's individual needs and preferences.

People's privacy, dignity and individuality was respected and they were supported and encouraged to make their own choices and decisions about their daily lifestyle routines.

We found the atmosphere in the home to be homely and relaxed and we observed positive interaction between the people who lived there and the staff supporting them.

Good

Is the service responsive?
The service was responsive.

All of the care plans were reviewed at regular intervals to make sure they include up to date information about people's lifestyle, routines, values and beliefs.

Daily records and notes made by staff helped to make sure that specific instructions about people's care were being responded to and followed to meet their needs and preferences.

People told us they knew how to make a complaint or raise a concern and were confident that anything they raised would be taken seriously and acted on by the manager.

Good

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

Good

Summary of findings

A manager registered with the Care Quality Commission was in place at the home and systems were in place to monitor and assess the quality of the service being provided.

People using the service and their families were provided with opportunities to express an opinion about how the service was managed and the quality of service being delivered.

There was evidence available to demonstrate that the service worked in partnership with local health and social care services.

Clarendon 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.

This inspection took place on 7 and 8 December 2015 and the first day was unannounced.

The inspection was carried out over two days by one adult social care inspector.

Before we visited the home we reviewed the previous inspection reports and notifications held on our records that we had received from the service. We also contacted the local authority quality team to seek their views about the home. They did not raise any concerns about the service.

On this occasion we did not ask the provider to complete a provider information return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

During the inspection we observed how the staff interacted with people using the service. We spoke with four people who used the service, the domestic on duty, four visitors, the cook, the kitchen assistant one senior health care assistant (SHCA), the visiting district nurse (DN) the deputy manager, the registered manager, the provider and three health care assistants (HCA's).

We walked around the home and looked in 16 bedrooms. We looked in both the communal sitting rooms, a dining room, the kitchen, the communal toilets and two bathrooms. We reviewed a range of records about people's care and support which included the care plans and medicine records of three people. We examined the staff training and supervision records for five staff employed at the home, and quality monitoring records such as auditing records about how the home was being managed.

Good

Is the service safe?

Our findings

Three people we spoke with told us they felt safe and had no complaints or concerns about the care provided. One person said, "I evidently had a lot of falls before I came here; this place is a mixed blessing because I need the support and I miss home, but I feel safe here", "I'm really comfortable here and I know the girls will keep me safe" and "I'm happy here, oh yes I feel safe enough; they [staff] won't see any harm come to us here".

The visiting district nurse (DN) made positive comments about the care provided to people living at Clarendon House and said, "I have no concerns about the safety of people who live here; the care is consistent, people are safe and looked after well".

There was a safeguarding procedure in place which was in line with the local authority 'safeguarding adults at risk multi agency policy' and staff spoken with knew that a copy of the policy was kept in the care staff office. Staff we spoke with had a good understanding of safeguarding issues and staff learning and development records showed that staff had received training in this topic. Information we held about the service indicated any safeguarding matters were effectively managed and reported to the appropriate safeguarding agencies.

Staff told us of the process they would follow when reporting any concerns about people's safety to the home manager. They were clear about how to report safeguarding concerns in a timely way to external authorities such as the local authority and the Care Quality Commission. Comments were made by two staff about the action they would take if they suspected abuse, such as, "if we suspect any abuse to people we'd report it to the manager immediately" and "I would have no problem reporting my concerns to the manager or the deputy, we need to make sure people are safe".

Staff also knew to be vigilant about the possibility of poor practice by their colleagues and knew how to use the homes whistleblowing procedure. They told us they would be confident if they needed to report any concerns about poor practice taking place within the home and one staff member said, "yes, we've done training on this; no problem at all reporting poor practice, and if I felt the manager wasn't doing anything I would go to you at CQC". Whistle blowing is when a person raises a concern about a wrongdoing that may place a person at risk of harm in the workplace.

From the three care files we looked at we saw that the manager had undertaken regular care plan reviews to make sure that people's risk assessments identified how risks would be managed and where possible mitigated. For example, we looked at two care plans and saw that any identified risks had appropriate management strategies in place to minimise the risk as much as possible.

We examined records of accidents and incidents in relation to people using the service and saw they were well documented and up to date. Monthly accident and incident audits were carried out and submitted to the local authority and analysed for any obvious patterns developing. For example where incident trends had occurred such as falls, the manager had introduced risk assessments following the incident to reduce the risk reoccurring. Also relevant referrals would be made to the appropriate health care professional for advice and guidance and any changes needed to the persons care plan would be completed and shared with the staff team. We saw that where necessary appropriate authorities such as the local authority adult safeguarding team and the Care Quality Commission had been notified in a timely way of such events.

The home had an up to date medicines policy and procedure for the receipt, storage, disposal and administration of medicines. The supplying pharmacy provided people's medicines through a monitored dosage system. This is a system where people's individual medication (tablets) had been pre-dispensed into individual medication pots and allows the home to comply with relevant legislation and good practice about medicines in care homes. We saw that medicines were stored safely in a locked metal medicines trolley which was securely kept in the nurse station at the home. Records were kept for medicines received and disposed of; this included controlled drugs (CD's).

We observed part of the morning medicines round and saw that medicines were administered following the homes procedure by a senior health care assistant (SHCA) who was trained to carry out this role. Other medication such as that to be given 'as and when required' such as paracetamol and liquid medication was administered directly from its

original packaging. We saw that the SHCA was wearing a red tabard indicating they were administering medication and should not be disturbed. This practice helped to prevent medication errors and make sure people received their medication as prescribed.

The senior health care assistants, the deputy manager and registered manager had received appropriate medication training and were responsible for administering medicines in the home.

We looked at the medicine administration records (MAR) for five people who lived at the home and found that the records had been completed accurately and were up to date. The MAR sheets showed that people were receiving their medicines as prescribed by their GP. We randomly checked the balances of two CD's and we found all balances to be correct and the CD records had been countersigned by a second SHCA.

When we asked three people if their medicines were administered on time they confirmed they were. During the medicines round we saw people were offered their medicines as prescribed in a sensitive and unhurried way.

There was a recruitment and selection procedure in place that was in line with the current regulations for recruiting staff to work in a care setting. We looked at five staff recruitment files and found that all of the files contained appropriate documentation to demonstrate that staff had been recruited in line with the regulations. This included the completion of a disclosure and barring service (DBS) pre-employment check and receipt of two appropriate references. The DBS is a service that identifies people who may be barred from working with children and vulnerable adults and informs the service provider of any criminal convictions recorded against the applicant.

The registered manager told us they always used the same two agency care workers to cover the staff rota at short notice. The agency staff confirmed this when asked. The registered manager and provider told us that any agency staff employed at the home had undergone pre-employment checks including a DBS check through their employment agency. Following these checks the agency staff had been interviewed by the manager using the same recruitment process used for the permanent care staff.

The registered manager and provider were unable to provide us with a record to verify these checks had been carried out and told us that these records were held with the employment agency. The provider told us that he would obtain the appropriate records from the agency immediately after our inspection and in future these records would be held at the service along with any other appropriate agency worker employment records. These pre-employment checks help the registered manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable people.

We asked the registered manager what systems were in place in the event of an emergency occurring that could affect the running of the home and the provision of care. We were shown the contents of a 'service continuity plan' that provided staff with relevant information should an emergency arise, such as electricity failure and gas leaks. We saw that a list of other care homes to be used on a short term basis should the building need to be evacuated had been listed. This information was also stored on a computerised memory stick (USB) so that the necessary information could be accessed away from the home. This meant that records and documentary information required to be used in an emergency was being kept safely and could be accessed at all times.

We saw that regular safety checks had been carried out to make sure the fire alarm, emergency lighting and fire extinguishers remained in good working order and that all fire exits were kept clear. We saw that these systems and checks were complete and in place when we walked around the home. This meant that equipment that might be used to protect people during an emergency was maintained safely and was in good working order.

We saw staff wearing uniforms and disposable aprons and gloves to prevent the risk of cross infection when carrying out their care duties. The local authority health protection and control infection unit had carried out an infection control assessment on 4 November 2015. The assessment looked at areas such as care management, care practices, communal areas, resident's rooms, and toilets. A designated person responsible for monitoring infection control issues at the home was in place and worked alongside the local authority infection control person. The home's designated infection control person was also responsible for making sure that people using the service

Good

Is the service safe?

and people working at the home had been offered the flu immunisation and Hepatitis B vaccination. These vaccinations helped to prevent people from becoming ill from serious and infectious diseases.

The home had achieved the highest food hygiene rating following a food hygiene and kitchen inspection carried out by Stockport local authority on 7 September 2015. This meant that the home were compliant with the local authority food hygiene procedures including kitchen cleanliness and the homes hygiene management and control procedures. When we looked in the kitchen, we noted that the kitchen, freezers and dry food storage areas were particularly clean and hygienic.

Armchairs, walking frames, and pressure relieving equipment were clean, well maintained and safe. We found that the shared bathroom and shower room had been cleaned regularly throughout the day. Handwashing soap, paper towels and antibacterial gel were readily available in toilets and shared areas around the home. We saw that the cleaning system in place helped to make sure the home was clean and any offensive odours apparent during our visit were attended to immediately.

Staff kept entrances and exits to the home clear. The front door of the home was secure so that staff could monitor who came in and left the building. This did not restrict people's movements. Records showed and from our observations we saw people could leave the home with appropriate supervision and safeguards in place if they wanted to.

Good

Is the service effective?

Our findings

Three people spoken with felt the staff had the right skills and training to meet their needs and one person said, "the girls [staff] are lovely; somehow they know if I have a pain and they get the doctor; I don't have to say anything, they just seem to know when something isn't right", "yes, they're nice girls; they seem to know what they're doing; they're good" and "they are good to me, they've helped me a lot. I think they know what they are doing and they do their job very well".

Three staff spoken with confirmed they had received a staff induction at the start of their employment at Clarendon House and this included a three month probationary period in which they had to shadow a senior member of staff for one week before they were allowed to work unsupervised with people. One health care assistant (HCA) said, "I wasn't confident after a week because I'd not worked in adult social care before, so I told the manager and then shadowed a senior carer for 12 weeks until I became confident". Two other staff including a SHCA confirmed that they had all undertaken core training in topics such as fire awareness, safe administration of medication, safeguarding, food hygiene, infection control and basic first aid. Training such as this helped to make sure that the staff knowledge, skill and understanding was up to date and they could meet people's needs effectively.

Information held on the staff training and development record and within staff files showed that staff had all received further training in topics such as safeguarding vulnerable adults, level two in dementia awareness, end of life care, catheter care and nutrition and hydration and whistleblowing. The registered manager provided documentary evidence that all of the staff team had undertaken appropriate training which was updated regularly and had enrolled on courses such as the National Vocational Qualification (NVQ) level two or three in health and social care.

The three staff we spoke with confirmed that they received regular supervision sessions and were awaiting their annual appraisal from the registered manager or deputy. From the five staff records we looked at we saw that these sessions were taking place regularly and the manager was in the process of planning future staff supervision sessions and to provide all staff with their annual appraisal before the end of January 2016. These meetings helped to make sure staff were regularly supported in their work. Staff made positive comments about their supervision and appraisal and said, "we call them three monthly reviews where we talk about how the job is going, training, individual tasks and our key worker role". This meant that staff were receiving appropriate support and guidance to enable them to fulfil their job role effectively.

We examined the staff training records that showed staff had undertaken training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of The Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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).

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

Three staff spoken with were clear about their responsibilities when these restrictions were in place. One member of staff said, "it's about people's capacity to make their own choices about what is best for them and their safety". Both the registered manager and deputy manager had a clear understanding about this legislation.

The registered manager provided us with details about the arrangements in place for people who used the service to give consent to their care and treatment. The manager said, "we are doing a monthly capacity assessment on everybody when we review them. We would involve a social worker if we felt the assessment needed to go to the next stage which would be a formal mental capacity assessment". Records showed that where people were unable to sign to agree about the care and support their

Good

Is the service effective?

relative had signed on their behalf because they had lasting power of attorney. Lasting power of attorney is a legal document giving someone else authority to act on their behalf.

From examining people's care records we noted that people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support to help make sure their day to day health needs were met. People were involved in regular monitoring of their health and from the records we examined and discussions with people using the service and their relatives it was apparent that people had regular access to healthcare professionals, such as a general practitioner (GP), dietician, optician and district nurses. During the inspection we heard staff making telephone referrals to the GP and district nurse and saw that people were supported to access both professional health care and support services in private at the home.

We saw that people were being provided with enough fluids during the day to keep them hydrated. One person said, "you can have as many drinks as you like, they're always coming round with tea and coffee". At the time of our inspection one person needed to have their fluid intake monitored and records showed this was being recorded regularly. The deputy manager told us that if a dietician had made recommendations for staff to follow the staff would monitor people's weight and dietary intake as required. At the time of the inspection nobody living at Clarendon House required support form a dietician.

Another person who was cared for in bed had their fluid intake closely monitored to minimise the risk of dehydration. We saw that the person was being supported with regular hydration and appropriate 'thickener' prescribed by the GP to aid their swallowing of food and drinks. The risk assessments we looked at had been reviewed and updated on a regular basis to help make sure the care provided would meet the person's changing needs.

Meals were made by the cook using fresh ingredients. We saw people being asked to choose their main meal option in the morning and a choice of different meals were made available to them. We saw that tables were set using table cloths, cutlery and drinking glasses and condiments were available. We noted that staff stayed in close proximity during the meal time to offer assistance to people if requested. Meal portions were of an appropriate size, they were balanced, nutritious and appetising to look at. Three people said about the meals served, "the food is very good and tasty, we can have whatever we want and there is always a choice", "they are very nice meals, always enough and more if we want" and "well it's not cordon bleu and I have to accept that I'm not going to get my wife's cooking here; but they'll do".

When we walked around the home we found that people's rooms were spacious and comfortably furnished. Shared bathrooms and toilets were spacious enough to manoeuvre a bath chair and bath hoist. Raised toilets and hand rails were in place to maintain people's independence. Shared lounge and dining room areas were warm and homely and people could sit in their room if they chose to.

A maintenance plan identified where the home required decorating and the renewal of furnishings which were included in an action plan with dates for the work to be completed. A communications book was used to record small maintenance jobs that were being completed immediately by the maintenance person before they became problematic or posed a risk to people.

Good

Is the service caring?

Our findings

People spoken with made positive comments about the care and support provided to them at Clarendon House. Comments made to us included, "I'm happy here and the girls [staff] are nice to me", "I'm really comfortable here, I'm well looked after" and "this place is a mixed blessing although I miss my home, I need the support; the staff are kind and help me to maintain my hygiene discreetly and privately".

Two relatives spoken with said, "I'm very comfortable with my relative being in Clarendon House. She's very fragile and the staff treat her very carefully, she's always clean and comfortable, they really look after her" and "the girls are angels and very well organised; nothing is too much trouble. I'd be upset if my mum had to move; they look after her really well".

We found the atmosphere at Clarendon House to be homely and relaxed and we observed staff chatting with people in a familiar but respectful manner which helped to make sure people's dignity was promoted. From our observations we saw staff caringly, making sure people were comfortable in their room or wherever they chose to sit in the home. Staff were attentive to people's needs and responded to people's requests with patience, kindness, warmth and friendship.

Staff spoken with told us they were nominated 'key workers' for individual people who lived at the home. A key worker is a member of staff who with the person's consent and agreement takes a key role in the planning and delivery of that person's care.

We were told that any care and treatment provided was always discussed and agreed with people who were able to consent. It was apparent that the wellbeing of people using the service was the central focus and the priority within the home. Care plans were written with the involvement of people and their relatives to help make sure they experienced care that was empowering regardless of the person's ability. Consent forms had been signed by people to agree to the care being delivered. For example a person using the service said "since I've been here they [staff] have discussed everything with me first, then they have spoken to my sons and we've decided on things together".

Throughout the inspection we noted that people were accorded a standard of care and attention which respected their individual preferences, their privacy and dignity, recognised their diversity and promoted their independence. We saw staff actively listening to people and encouraging them to make informed decisions about their day to day actions such as choosing meals, where they wanted to sit in shared spaces and requests for staff to support people with their mobility.

Staff told us they had been trained in how to respect people's privacy and dignity, and understood how to put this into practice by making sure that any care intervention would be carried out away from communal areas and making sure discussions about a person's care needs would be carried out in the person's room or the nurse station.

The registered manager advised us that where necessary people would be assessed by a social worker to determine any advocacy representation needed to help make decisions about their health and wellbeing. Advocacy services are designed to support people who are vulnerable or need help to make informed decisions and secure the rights and services to which they are entitled.

We examined the home's policy and procedure in relation to end of life care which was to provide high quality care with dignity and compassion for people nearing the end of life, abiding by the appropriate customs of religious culture and practice and supporting the person's family throughout. This policy also considered how the needs of people using the service and their relatives could be met and at what stage 'extra' care and support should be delivered.

The registered manager told us that health care professionals such as a GP and district nurse would always be involved to help make sure people could be cared for at the end of their life in the place and manner of their choosing. Such policies, procedures and training enable people who use the service to receive high quality end of life care provided by staff in a compassionate and understanding manner.

Good

Is the service responsive?

Our findings

Three people who we spoke with told us they felt their needs were being met by the staff who worked at Clarendon House. They made positive comments such as, "I've had a thorough going over. They've washed and dressed me. I had a lot of falls before I came in here. Not fallen since, but I need the support and the girls are very helpful. The staff are kind too", "The staff are very good, they know me well and keep me safe; I have everything I need here and they attend to my needs very well thank you" and "Some staff don't speak English very well but I can understand them and they seem to know what I need; I have everything I need and like to spend my time in my room. They [staff] check up on me regularly".

Two relatives spoken with also made positive comments about the way the care was delivered to their relatives. One said, "I'm very comfortable with my mum being at Clarendon House; the staff are very helpful and always keep me up to date with their care. Any care delivered is always done properly. I have another relative living at Clarendon House and she's always clean and looks comfortable. They [staff] always make sure her mouth is cleaned with a mouthwash using a swab. We have discussed resuscitation options, I have power of attorney and I've signed all of the forms. If there is the slightest thing the manager will phone me. They always reassure me and explain what action they have taken for example, when my mother had a urine infection they were straight on to me to advise me of her [mother's] antibiotics. We went through a raft of risk assessments with the manager and my mother. The manager made it clear how they were looking after her. There's never a bad odour at the home either". Another relative said, "these girls [staff] are angels, very well organised and nothing is too much trouble. The staff really are brilliant, very competent and caring staff team. I know my mum is happy with the home. She has a nice room, plenty of space and is always comfortable when I see her. The manager always phones me if there are any changes to my mums care and they keep me up to date about her health".

We looked at the care records that belonged to five people and saw that each person's care plan had been written to make sure people received appropriate care, treatment and support to meet their needs and protect their rights. The care plans we looked at were clearly written and centred on the person as an individual. The care plans showed that people had received a care needs assessment before they moved into the home to help make sure that care would be delivered in response to those needs.

From the five care plans we looked at, each one contained information about their general history, family life, and other relevant information where necessary. The care plans were based on all the information gathered about the person, assessments of known risks and monthly reviews of care plans and associated documentation. Where the assessment information identified a person needed support in a particular area such as poor skin integrity a written care plan was put in place providing guidance to staff on the support the person required. We saw that care plans were written in a person centred way and where possible people had signed to show their involvement in their care plan review or development.

We saw records that confirmed risk assessments had been reviewed monthly or more frequently, if people's immediate needs required monitoring. We saw staff frequently checking on particular people where risks had been highlighted such as risk pressure sores. Written care instructions were responsive to people's individual characteristics so that their needs would be met based on best practice and professional guidance from the GP, district nurse or dietician. Daily shift handovers and written notes made by care staff helped to make sure that specific care instructions were being followed and responded to by the staff team. Medical and health care meetings were used to plan and agree people's ongoing care and to check that people using the service were receiving the care and support that met their identified needs.

We saw there were a variety of activities displayed on a notice board in the home's reception area available for people to take part in if they wanted to. The activities board listed things people could do such as; board games, beauty treatments, hairdressing, sing a long and an entertainer visited the home every six weeks. People were encouraged to participate however it was respectfully acknowledged when people declined the invitation. We saw that a list of activities appropriate to peoples likes and dislikes were recorded in their individual care plan.

There was a complaints procedure in place which was available to people who used the service and their relatives. People spoken with knew their concerns or complaints would be taken seriously and acted on by the

Good

Is the service responsive?

manager. Any action taken followed the homes procedure for dealing with comments and complaints. From the records we looked at any complaints or comments made had been addressed immediately and satisfactorily.

Good

Is the service well-led?

Our findings

The home had a manager in post that had been registered with the Care Quality Commission (CQC) since January 2011 at this location. The registered provider owner attended the home on the first day of the inspection. We saw that both registered manager and registered provider were clear about their roles and responsibilities for making sure that the quality and safety of the care provided met the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had purchased a fundamental standards compliance toolkit which contained working examples of how to meet the five key questions and topic areas which ask; is the service safe, effective, caring, responsive and well- led. This toolkit helped to keep the manager and provider up to date and aware of any changes within the regulations, provided a quality assurance process to help consistently monitor the service quality and generate improvement within the service. The registered manager also used this system to monitor concerns and risks and to check and evaluate the service's approach to the service delivery and outcomes. The toolkit also included up to date policies and procedures to support the daily running of the home and to help make sure that staff were clear about their duties when they were involved with all aspects of people's healthcare and wellbeing.

There was a clear management structure in the home which was visible at all levels and it was apparent staff knew what they should be doing in terms of tasks at specific times during the day. The registered manager and deputy manager understood their responsibilities and led an experienced staff team to make sure people were given the best care possible in a safe, effective, caring and responsive way.

Staff spoken with told us they knew the role and responsibilities of the management team. They were able to demonstrate through discussion their responsibility to make sure that the care being provided to people was safe, responsive , caring and effective and said, "we know it's important to make sure the people who live here are well looked after and safe; it's like looking after your parents; we just want the best for them". They told us that the managers were approachable and were always present in the home. During the inspection we saw that communication between the manager and staff was seen to be effective and the systems in place helped to maintain this.

People who used the service and relatives we spoke with told us the registered manager and the deputy manager were both very approachable. People made positive comments such as, "I can talk to the manager anytime, they are all very nice and make time for you" and "they are well organised and know what they are doing".

The registered manager collected data regularly by checking that each person's care plan records were in good order and included the relevant up to date information to meet people's needs and keep them safe. Further information about how care was delivered, medicines management, people's choice and involvement were monitored weekly and information gathered was audited monthly. We saw that people's care plans had been checked using the auditing system. Any inaccuracies or shortfalls in care plans were identified and updated to reflect the person's needs. Changes made in the care plans were highlighted within the audit records and this information was shared with the staff team. In addition to this the registered manager carried out a three monthly food safety, waste disposal and a sharps (needles) handling and disposal audit to help identify and mitigate the risks of harm to people using the service and staff.

Records showed that the manager recorded and investigated incidents and falls that happened in the home and had taken the appropriate action to reduce the risk of them happening again through the use of a falls auditing and incident reporting system. The registered manager completed a falls audit for each individual person and had notified the CQC of any incidents and events as required. The falls audits also linked into an environmental audit which was completed every three months and we saw that the last one was completed in September 2015. From looking at our records and data collected via the audits we saw that risk to people was minimised because the systems in place for monitoring risk were effective.

A recent medication inspection undertaken by the Stockport National Health Service (NHS) Clinical Commissioning Group (CCG) on 16 September 2015

Good

Is the service well-led?

showed that people's medication in the home was being well managed and there was very little extra stock being stored in the home, which helped to prevent potential medicine errors from occurring.

We looked at notes from a staff meeting last held in July 2015 and on 15 September 2015 that showed staff meetings had taken place and were ongoing in the home. Staff signed to confirm their attendance or that they had read the meeting notes. These meetings were frequent and a discussion with the registered manager confirmed her intention to increase the frequency of staff meetings in the new year to introduce the new policies and fundamental standards compliance toolkit. Staff also confirmed that regular 'informal' staff meetings had taken place when necessary or following a shift handover specifically to discuss any concerns to people's health and wellbeing which would help to make sure that risks to people are minimised.

The last service user satisfaction survey was completed in November 2014 and showed that overall people were very satisfied with the service provided. Any issues raised for example replacing the signage on peoples bedroom doors and helping people to recognise who their keyworker is was an ongoing project.

The manager was trying different methods to help support people with dementia to improve their recognition of previous events. The manager said about their vision for future development, "I think the recognition support for people with dementia will be an ongoing project which we will look at individually for each person. After Christmas, I will be sending a satisfaction survey out to the resident's and their relatives. We didn't get much feedback last time, but people tell us all the time they're happy here and we get constant positive feedback when we talk to people and their relatives daily".