St. Martin's Care Limited

Washington Manor 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

This was an unannounced inspection which took place on 29 June and 5 July 2018. This meant the staff and provider did not know we would be visiting.

We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

At the last inspection in May 2017 the service was not meeting all of the legal requirements with regard to regulation 10, dignity and respect, regulation 11 need for consent and regulation 18, staff training.

Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to remedy the breaches of regulations.

At this inspection we found improvements had been made and the service was no longer in breach of regulations 10, 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Washington Manor is a care home. People in care homes receive accommodation and 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.

Washington Manor accommodates a maximum of 68 older people who require personal care, some of whom may live with dementia or a dementia related condition. At the time of inspection 57 people were accommodated at the home.

A registered manager was in place. 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.

People said they felt safe and they could speak to staff as they were approachable. People and staff told us they thought there were enough staff on duty to provide safe care to people. Staff knew about safeguarding procedures. Staff were subject to robust recruitment checks. Arrangements for managing people's medicines were safe. However, we have made a recommendation about the management of medicines.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Activities and entertainment were available to keep people engaged and stimulated.

The home was being refurbished and people were very positive about the changes taking place. There was a good standard of hygiene. The environment promoted the orientation and independence of people who lived with dementia.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received a varied and balanced diet to meet their nutritional needs.

Appropriate training was now provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. 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.

Detailed records reflected the care provided by staff. Care was provided with kindness and people's privacy and dignity were respected. Communication was effective to ensure people, staff and relatives were kept up-to-date about any changes in people's care and support needs and the running of the service.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people and family members and their views were used to improve the service. All people were complimentary about the changes that had taken place in the home.

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 kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Regular checks were carried out to ensure the building was clean, safe and fit for purpose. Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe and timely way.

Appropriate infection control measures were in place and there was a good standard of hygiene.

Is the service effective?

Good

The service was effective.

Improvements had been made to staff training, Staff received a range of training to give them an insight into people's needs.

People's rights were protected. Improvements had been made to best interest decisions so they were made appropriately on behalf of people, when they were unable to give consent to their care and treatment. However, we have made a recommendation about best interest decision making when covert (without the person's knowledge) medicines were used.

People received a varied and balanced diet.

The home was being refurbished and the environment promoted the orientation of people who lived with dementia.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were compassionate, kind and caring.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People maintained they were kept involved in daily decision making.

Is the service responsive?

Good

The service was responsive.

There was a good standard of record keeping. Staff were knowledgeable about people's needs and wishes. We advised further information should be documented about people's end of life wishes and the management of distressed behaviours to complement existing information.

There were activities and entertainment available for people.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was available to give advice and support.

All people were positive about the changes being introduced by the provider and registered manager.

Staff informed us that they enjoyed working at Washington Manor and they worked as a team.

The home had a quality assurance programme to check on the quality of care provided.

Washington Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 June and 5 July 2018 and was unannounced.

The inspection team consisted of one adult social care inspector on the first day and an expert-by-experience accompanied the inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR 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 PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are reports of changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and other professionals who could comment about people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 15 people who lived at Washington Manor, eight relatives, the

registered manager, the operations manager, a quality partner, the administrator, the deputy manager, the cook, kitchen assistant, eight support workers including two senior support workers, the activities co-ordinator and a visiting health care professional. We looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for seven people, recruitment, training and induction records for four staff, five people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

People told us they were safe living at the home. One person commented, "I am safe in every way, I trust the staff." Another person told us, "I do feel safe here, in my bungalow I locked everything, here I lock nothing." A third person told us, "I have no reason to feel unsafe." A relative commented, "I know [Name] is safe when I leave, which is a weight off my mind, a big weight off my mind."

Our observations during the inspection showed, at current occupancy levels, there were sufficient numbers of staff available to keep people safe. The registered manager told us staffing levels were determined by a dependency tool. This was used to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely.

People also confirmed there were enough staff. One person told us, "There are always enough staff to hear me, if I should fall." Another person said, "I haven't found difficulty in getting staff. Nothing is too much trouble, when I need them [staff] they are there." Other people's comments included, "I think there are enough staff, as you can see there is always someone around", "I sometimes get up for a cup of tea at 2:00am, I just ring my bell and they [staff] come", "Yes I think there are enough staff" and "When I need them [staff] they are there." A relative told us, "There always seem to be enough staff on duty when I visit." A second relative said, "There seem to be enough staff, although they are kept busy." A visiting professional commented, "I think there are enough staff. Things have improved since the new manager has come to the home." A staff member told us, "There are enough staff and we get cover when someone is off."

There were 57 people living at the home at the time of inspection. The registered manager told us 24 people on the top floor were supported by four support workers including a senior support worker. On the ground floor, 33 people were supported by six support workers including a senior support worker. Staff told us additional staff were on duty in the morning during busy periods when people were getting up until 11am. Overnight staffing levels included six support workers.

Staff had undertaken safeguarding training about how to recognise and respond to any concerns. Staff we spoke with were able to clearly describe the appropriate steps they would take if they were worried about people's safety or wellbeing. One staff member commented, "I would report any concerns to a senior or the manager." Safeguarding records showed prompt referrals had been made to the local authority safeguarding team, and investigations had been undertaken where necessary.

Regular analysis of incidents and accidents took place. The registered manager told us accidents and incidents were monitored. Individual incidents were reviewed within 48 hours and a monthly analysis was carried out to look for any trends. They told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration

records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment rooms. A system was in place to record and monitor fridge temperatures daily to ensure refrigerated medicines were kept at a suitable temperature. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

People's individual risk assessments were in place with a system of review to ensure they remained relevant, reduced risk and kept people safe. The risk assessments included risks specific to the person such as moving and assisting, choking, nutrition and pressure area care. The monthly evaluations included information about the person's current situation. Environmental risk assessments such as the use of oxygen, fire, falls from windows and the kitchen environment were in place with a regular monthly review to ensure they remained accurate and reflected any current risk around the home.

Robust recruitment processes were in place. This included thorough checks of applicants for any role. The service ensured the correct information was available in personnel files. This included proof of identity, criminal history checks, and references from prior employers, job histories and health declarations. The service ensured only fit and proper persons were employed to care for people.

There were appropriate emergency evacuation procedures in place. Regular fire drills had been completed and all fire extinguishers had been regularly serviced. A person commented, "We have a fire drill at least once a week." Arrangements were in place for the on-going maintenance of the building. The building was clean with a good standard of hygiene. One person told us, "The place is clean and tidy." Protective equipment was available and used appropriately by staff to reduce the spread of infection.

Good

Is the service effective?

Our findings

At the last inspection in May 2017 we had concerns that staff had not all received training specific to their job role. After the inspection the provider sent an action plan to show staff would all have completed this training by June 2017.

At this inspection we found improvements had been made and the service was no longer in breach of this requirement.

The staff training records showed and staff told us they had received training to meet people's needs and training in safe working practices. Staff training courses included, diabetes awareness, epilepsy, falls awareness, dignity and choice, person-centred care, dementia care, dysphagia (swallowing difficulties), oral health, mental capacity and food and nutrition. Staff made positive comments about the support they received and training attended. One staff member told us, "I have just completed a National Vocational Qualification (NVQ) at level two and after a break I want to do an NVQ (Now known as the Diploma in health and social care) at level three." Another staff member commented, "I did behaviour management training and we were shown how to use charts to record when someone was upset." Other staff comments included, "There are opportunities for training", "I did falls training and got a certificate for it", "We have to complete booklets when we do the training, it is not e learning", "I have done mental capacity training", "My training is all up -to-date", "Training is face-to-face but we have to travel some distance to get the training, we usually go to another home where it's happening", "We get training all the time", "I've done safe handling of medicines, care planning and first aid, so far this year", "We go to Darlington for training, it is a long way to travel without a car and when the course may only be two-three hours", "I would like to do some medicines training, although I don't give out medicines", "There is safeguarding training next week", "It can be difficult to get to training, I try and get a lift" and "I get regular training."

Staff members were able to describe their role and responsibilities. Newer staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. One staff member commented, "Induction gives us a base line about care." Another staff member commented, "I did some shadowing when I started here." The registered manager told us staff studied for the Care Certificate in health and social care as part of their induction training. (The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.)

All staff told us they were supported in their role. Support staff said they received regular supervision to help them carry out their role and an annual appraisal system was in place. One staff member told us "I have supervision every two months." Another member of staff said, "Supervision does happen about four times over the year and we get an annual appraisal." Other staff member's comments included, "A senior supervises me", "I supervise five care staff" and "I get supervision every two months with a senior staff member."

We also had concerns at the last inspection that some best interests decision making, where people did not

have mental capacity, had not always been appropriately made in relation to equipment that restricted people's movement. At this inspection we found improvements had been made and the service was no longer in breach of this requirement. However, we considered some improvements were still required.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that all DoLS applications were clearly documented and stored and that where people were being restricted or controlled then this was done so in their best interests and the least restrictive option was always considered. We observed staff demonstrated a sound understanding of their duty to promote and uphold people's human rights. The registered manager had submitted DoLS applications appropriately and told us 28 authorisations were in place, one application had been submitted for processing by the local authority and three authorised DoLS were due to be renewed.

Records showed that assessments were now carried out to check people's capacity and understanding with regard to specific decisions. For example, for the use of bedrails and lap-straps on wheel chairs. They also recorded who was involved in the decision-making process where decisions were made in people's best interests.

However, where people lacked mental capacity to be involved in their own decision making, the correct process had not always been used with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines. Documentation did not show a best interests decision had been made with the relevant people that included care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in their best interests.

We recommend the registered manager considers the most up-to-date best practice guidelines on managing medicines in care homes.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place.

People were supported to maintain their healthcare needs. One person commented, "If I am poorly I see a nurse and then a doctor straight away." Another person said, "If you are ill they [staff] are there." People's care records showed they had regular input from a range of health professionals. For example, staff referred people who were at risk of poor nutrition to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause.

Systems were in place to ensure people received varied meals at regular times. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's

dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. People received drinks in between meals and the tea trolley provided a variety of drinks and biscuits. One person commented, "I like the fact that fruit is brought around, as a healthy option."

We observed the lunch time meal. Food was well-presented and looked appetising. People and relatives were positive about the food. One person told us, "I like breakfast best, it is beautifully prepared." Another person said, "I have no problem with eating, it is very difficult losing weight here, I am putting weight on." Other people's comments included, "There are plenty of drinks", "I am well-fed" and "I am a teapot you can see why."

The home was spacious, bright and airy. A programme of refurbishment was taking place and people and relatives were very positive about the changes. One relative told us, "The maintenance is very good. Everything has been decorated and new carpets, no expense spared." The communal areas and hallways of the home had decorations and pictures of interest and sitting areas were available around the home. Lavatories, bathrooms and bedroom doors were different colours and signed for people to identify the room to help maintain their independence. The environment for people who lived with dementia was "enabling" to promote people's independence and involvement. It was stimulating and therapeutic for the benefit of people who lived there. Pictures and signs were available to keep people orientated and involved and to help maintain their independence. There were tactile objects, displays and themed areas of interest on the corridors for people as they moved around.

Good

Is the service caring?

Our findings

At the last inspection in May 2017 we had concerns that staff did not all respect people's privacy and dignity. After the inspection the provider sent an action plan to show how this would be improved.

At this inspection we found improvements had been made and the service was no longer in breach of this requirement.

People's privacy and dignity were promoted and respected. People told us staff were respectful. We observed that people looked clean, tidy and well-presented. One relative told, "Look how clean [Name] is, staff brush their hair and look after them very well." We observed staff knocked on people's doors before entering their rooms, including those who had open doors. Care records documented a person's preference for gender of support worker in order to protect their dignity when they were assisted with their personal care. For example, "[Name] prefers a female carer."

During the inspection there was a pleasant and lively atmosphere in the home. Staff appeared to have a good relationship with people and knew their relatives as well. One relative commented, "Everyone knows my name and says "hi" when I come in. They [staff] make me a cup of tea whenever I want." There was a camaraderie between people as some people sat in the comfortable sitting areas on the corridors. There was friendly banter between staff and people as staff bustled around. People appeared calm and relaxed as they were supported by staff. People and relatives all said staff were kind, caring and patient. One person commented, "I am well-cared for and staff are very good." Another person said, "Staff chat away and listen to me." Other people's comments included, "Staff are very understanding", "I would not like to be anywhere else, I am happy here", "This is my home", "We are well-looked after as they [staff] always put our feelings first", "Staff stop and listen when they are not too busy", "It is a very good friendly atmosphere here, it feels like home", "Staff know their duties and their job and look after us" and "If staff can help they will." A relative commented, "It is exceptional care, I would not change anything." Another relative told us, "The caring is spot on. I do believe the staff genuinely care."

People were supported by staff who were warm, kind, caring and respectful. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the inspection, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. For example, "

Care was provided in a flexible way to meet people's individual preferences. People told us they made their own choices over their daily lifestyle. For instance, people had the opportunity to have a lie-in. They told us they could go to bed when they wanted and staff respected their wishes. One person told us, "I can get up and go to bed when I want." Another person said, "I am showered frequently, if I want." A third person commented, "You don't have to join in the activities if you don't want to. You can do your own thing." Some people told us they had been offered a key to lock their door if they wished.

We observed the lunch time meal in the dining rooms. People enjoyed a predominantly positive dining

experience at meal times. No one was rushed and people could eat their meal at their own pace. Staff were supportive to people and offered full assistance as required. Staff mostly offered constant encouragement to people, for example, "You are doing really well, would you like some more?" and "Can you do that by yourself?" In the main top floor dining room we saw that not all staff were aware when some people required assistance, prompting or encouragement to eat their meal. We discussed this with the registered manager who told us it would be addressed. We heard staff ask people for permission before supporting them, for example with assisting them to the dining table or offering them protective clothing at the meal. Food was well presented and looked appetising and hot and cold drinks were served. A choice of main meal was available at each meal. People sat at tables that were set with tablecloths, napkins and condiments. One staff member commented, "Mealtimes are not just about the food we eat, it is about who you eat it with, where you sit and is it comfortable."

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Some practices were in place to ensure people who lived with dementia were encouraged to make a choice and be involved in decision making. For example, with regard to drinks and other activities of daily living. One support plan stated, "Staff to offer choice to [Name] by reading the menu to them to see what they want to eat." However, we discussed with the registered manager that we did not observe people being offered two plates of food at the meal time to help them make a visual and sensory choice if they no longer understood the spoken word. They told us that this would be addressed.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff told us they also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. Accessible information was displayed around the home such as pictorial menus and activities board to help keep people involved in decision making.

People's care records contained information about people's likes, dislikes and preferred routines. Examples in care records included, "I would like people to sit with me and have a cup of tea and they can remind me where I am", "I enjoy knitting", "I enjoy listening to music" and "Ask [Name] about their dancing days." This information was important to help ensure staff provided person-centred care when the person was unable to tell staff about their routines and how they wanted their care to be delivered.

Good

Is the service responsive?

Our findings

People confirmed they were well-looked after by staff. One person commented, "Staff are very helpful getting me out of my chair as I can't walk and would fall over." Another person told us, "Staff are able to do whatever you ask them." Other comments included, "My care plan is in the office, my relative see it when they come", "Staff encourage me to do what I can" and "They [staff] are always trying to keep you mobile and independent."

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service.

Care plans were developed from assessments that outlined how people's needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Reviews of peoples' care and support needs took place with relevant people. A relative commented, "We have had talks about [Name]'s care plans, I have been to a meeting where they have discussed the plans and aims for the future."

Care plans were in place that provided details for staff about how the person's care needs were to be met. Care plans provided some detail of what the person could do to be involved and to maintain some independence.

Some people with distressed behaviour were referred to the positive behaviour team when more advice and specialist support was needed to help support the person. This advice was incorporated in some people's behavioural plans to help staff provide care to the person. However, care plans were vague, for some other people who may show agitation or distress. For example, a care plan which stated that staff should distract a person when they became upset, did not record how the person should be distracted. The care plan did not give staff detailed instructions with regard to supporting the person. Information was not always available that included what might trigger the distressed behaviour and the staff interventions required. This would help ensure staff all worked in a consistent way with the person to help reduce the anxiety and distressed behaviour. We discussed this with the registered manager who told us it would be addressed.

Staff completed a daily accountability record for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans. Charts were also completed to record any staff interventions with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs.

Records showed the relevant people were involved in decisions about a person's end of life care choices

when they could no longer make the decision for themselves. People's care plans detailed the 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs. We advised the registered manager although health care information was available about people's end of life wishes, other information was not available so their wishes could be met at this important time. For example, if there were any spiritual or cultural preferences during the final days, the type of service and arrangements after their death. The registered manager told us that this would be addressed. They described with compassion the funeral and service they had recently arranged for a person who had no relatives trying to ensure their likes in life were reflected.

An activities person was employed. An activities programme was available on each floor that advertised daily activities. Activities included, bingo, board games, dominos, reminiscence, knitting, arm chair exercises, pamper sessions, sing-a-long, film afternoons and pat- a-dog. A record of activities was maintained and people were offered the opportunity to be involved, if they wished. People confirmed activities, seasonal entertainment, parties and organised trips took place. One person commented, "I like bingo and all the activities." Another person said, "There is always something going on." A third person told us, "We have good fun in here." Other comments included, "Everyone can get involved and the time flies" and "We could do with a mini bus."

People knew how to complain. People we spoke with said they had no complaints. One person commented, "Complaints, it is the opposite in fact. No one has anything to complain about." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated. Several compliments were displayed that had been received commending staff on the care provided.

Good

Is the service well-led?

Our findings

A registered manager was in post who had become registered with the Care Quality Commission in July 2017. 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 registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary.

We found that breaches of regulation and areas for improvement identified at the last inspection had been acted upon. At this inspection we found improvements had been made and the service was no longer in breach of its statutory requirements.

The registered manager was enthusiastic and had introduced ideas to promote the well-being of people who used the service. Staff and people we spoke with were all very positive about their management and had respect for them. Comments included, "Best place I have worked", "Things have improved since the new manager started", "The home is better now this manager is here", "The manager is very approachable", "The manager is brilliant", "Staff have an open relationship with the manager" and "The manager and all the staff are approachable."

The registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and staff were open to working with us in a co-operative and transparent way.

The registered manager promoted amongst staff an ethos of involvement to keep people who used the service involved in their daily lives and daily decision making. The culture promoted person centred care, for each individual to receive care in the way they wanted. The registered manager told us, "People have their own front doors, this their home, they are not classed as bedroom doors. Staff respect this philosophy when they come to work."

A quality assurance programme included daily, weekly, monthly and quarterly audits. Audits included checks on the environment, finances, medicines management, care documentation, training, kitchen audits, accidents and incidents, infection control and nutrition.

All audits showed the action that had been taken as a result of previous audits. A risk monitoring report that included areas of care such as safeguarding, complaints, infection control, pressure area care and serious changes in a person's health status was completed by the home and passed to the office for analysis.

Monthly audits included checks on care documentation, people's dining experience, staff training,

medicines management, home presentation, complaints management, health and safety and accidents and incidents. Monthly visits were carried out by the provider's representative who would speak to people and the staff regarding the standards in the home.

The atmosphere in the service was warm, welcoming and open. A variety of information with regard to the running of the service was displayed to keep people informed and aware and this included the complaints procedure, safeguarding, advocacy and forthcoming events.

People and their relatives were kept involved and consulted about the running of the service. Regular meetings took place with relatives and people who used the service and minutes were available for people who were unable to attend.

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. One staff member commented, "Staff meetings happen regularly.

Staff said communication was effective within the home. A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. One staff member told us "Communication is effective."

The provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service and relatives. Results from the last provider survey in 2017 were advertised. "You said, we did," advertised actions that had been taken in response to people's comments. The environment was being refurbished and there were more activities taking place.

Staff, people and relative's comments that were made during the inspection were overwhelmingly positive. Comments included, "The home is lovely", "Everyone gets on, we don't want for anything, we get well-fed. I wouldn't change anything," "It is a very good friendly atmosphere", "This is paradise in comparison to some places", "Staff are definitely caring and well-trained" and "Staff have to be well-trained to work here."