HC-One Oval Limited

Rowan Garth 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 unannounced inspection took place on 30 July and 2 August 2018.

Rowan Garth Care Home is registered to provide nursing and residential care for up to 120 people. The service is set in pleasant spacious grounds and is situated in a suburb of Liverpool close to the city centre. The service consists of four single-storey units and provides care to people with both nursing and residential needs. Two of the units specialise in dementia care. Each of the units has its own dining room, lounge, quiet/library area and unit manager's office. At the time of the inspection 106 people were living at the service.

Rowan Garth is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of our inspection a temporary manager was in post as the registered manager had recently left the service. A registered manager is a person who has registered with CQC 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.

Each of the people we spoke with told us they felt safe living at Rowan Garth. Staff we spoke with understood their responsibilities in relation to safeguarding people from abuse and mistreatment and were able to explain how they would report any concerns.

Arrangements were in place with external contractors to ensure the premises were kept safe.

We found that medicines were managed safely. Medicines were stored correctly and were administered by staff who were trained to do so.

We looked at how accidents and incidents were reported in the service and found they were managed appropriately.

Staff's suitability to work at the home had been checked prior to employment to ensure that they were suitable to work with vulnerable people.

People's care requirements were identified and recorded in their care records. We also saw that people were appropriately referred to external health professionals when required. This helped to maintain people's health and well-being.

People and their relatives were involved in the formulation of their care plans. We saw that people's

preferences were considered. Staff supported people in a person-centred way and treated them with respect.

Staff sought consent from people before providing support. Staff we spoke with understood the principles of the Mental Capacity Act 2005 (MCA) to ensure people consented to the care they received. The MCA is legislation which protects the powers of the people to make their own decisions.

We found there were enough staff on duty to meet people's needs. Interactions we observed between staff and people living in the service were warm and caring. Staff treated people with respect and took care to maintain people's privacy and dignity.

There was an open visiting policy for friends and family. This helped people feel supported. For people who had no one to represent them, the service supported them in finding an advocate to ensure that their views and wishes were considered.

The service employed three activities co-ordinators who facilitated varied daily social activities between the units. People told us they could take part and have a say in what activities they would like to do.

We asked people what they thought about mealtimes and feedback was mixed. People told us they had a choice of main meal and the menu rotated monthly. We spoke with staff and found they were knowledgeable about people's preferences and dietary requirements.

The home had a complaints procedure in place. People and staff told us they would feel comfortable in raising any concerns they had with the manager.

The service was clean and easy for people to navigate. We have made a recommendation about making the environment more suited to the needs of people living with dementia. For example, better signage to help orientate people to toilets and bathrooms and painting doors to people's bedrooms different colours to help them identify their own room.

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.

Risk assessments had been undertaken to support people safely and in accordance with their individual needs. They were regularly updated to reflect any changes in people's needs.

Staff had completed training in safeguarding vulnerable adults and we were aware of the action they would take to ensure actual or potential harm was reported.

The premises were safe and well maintained.

Medicines were managed and administered safely in the service.

The provider had recruitment practices in place to ensure staff were suitable to work with vulnerable adults.

There were enough staff on duty to ensure people's needs were met.

Is the service effective?

Good

The service was effective.

Deprivation of Liberty Safeguards applications had been made appropriately and consent was sought in line with the principles of the Mental Capacity Act 2005.

Staff were knowledgeable in their understanding of supporting people when they lacked capacity to make informed decisions.

Staff were supported in their role through training and regular supervisions.

Appropriate referrals were made to relevant health professionals to maintain people's health and wellbeing.

Staff were knowledgeable about people's dietary requirements and preferences.

Is the service caring?

Good

The service was caring.

Interactions between staff and people living at the service were positive.

Staff used forms of non-verbal communication for those people who could not speak.

We observed people's privacy and dignity being protected during the inspection.

Family and friends could visit when they chose.

Is the service responsive?

Good

The service was responsive.

Care plans were written for the individual and informed staff of people's preferences and wishes which were supported. Staff were knowledgeable regarding people's care needs and preferences.

Activities were provided both in groups and on a one to one basis and were based on people's preferences.

Systems were in place to gather feedback from people and listen to their views. People knew how to make a complaint if needed.

Is the service well-led?

Good

This service was well led.

Systems were in place to monitor the quality and safety of the environment and identify any concerns.

Policies and procedures were in place to provide staff with guidance.

Feedback was sought regularly from people living at the service, their relatives and staff to ensure standards were being maintained.

Feedback regarding the overall management of the service was positive.

Rowan Garth 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 checked 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 30 July and 2 August 2018 and was unannounced on the first day. The inspection was conducted by two adult social care inspectors, a specialist advisor who was a registered nurse by background and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked the information we held about both the service and the service provider. This included 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 any improvements they plan to make. We also looked at any statutory notifications received and reviewed any other information we held prior to visiting. A statutory notification is information about significant events which the service is required to send us by law. We also invited the local authority commissioners to provide us with any information they held about the service. We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the current manager, the training manager, the activities co-ordinators and 14 members of care staff. We also spoke with 12 people who lived at the service and 10 relatives.

We looked at 13 care records, 13 staff recruitment files, a sample of medication administration records, policies and procedures and other documents relevant to the management of the service.

We also looked around the premises to ensure they were clean and safe for people who lived at the service.

We used a number of different methods to help always understand the experiences of people who lived at the service. We undertook general observations of the service and the care people received. We also used the Short Observational Framework for Inspection(SOFI). SOFI is a way of observing care to help understand the experience of people who could not talk to us.

Good

Is the service safe?

Our findings

We spoke with people who told us they felt safe living at the service, one person told us, ''I feel safe here.'' Another person told us, ''I was prone to falls [at home] and the doctor came out but I haven't fallen here.'' A relative told us, ''I just want to feel [my relative] is comfortable and safe, and they are. The staff check everything all the time. There seem to be enough staff around in the day.''

People had their own call bells and there were emergency call bells in the communal areas. We saw that for people who were not able to use a call bell, additional measures were in place such as regular checks on the person.

We spoke to staff to check their understanding around safeguarding people from abuse, maltreatment and neglect. Training records showed that staff had received training in this area and staff we spoke with were aware of the procedures in place to follow regarding any suspicion of abuse. All staff we spoke with told us they would not hesitate to report any concerns or signs of mistreatment or abuse. One staff member told us, ''I would tell the nurse in charge if I had any concerns. I also know that I can go to the local authority safeguarding team or CQC.''

We looked at how staff were recruited within the service. We looked at 13 staff personnel records to see if appropriate checks had been carried out to ensure they were safe to work at the service. We saw that previous employer references had been obtained prior to employment and criminal conviction checks had been made.

We looked to see if the service had enough staff to meet people's needs. The service used a dependency tool to help ensure there was enough staff on duty at any one time. The service deployed different numbers of staff to each unit given that people on certain units had more complex health care needs. We looked at staff rotas for the last four weeks and found there were sufficient staff available to meet people's needs and that staff responded in a timely manner when people required assistance. One person told us, ''Oh yes there are [enough staff on duty]. They come quickly [if call bell is used]; they're always on hand.''

We looked at the systems in place for managing medication in the service. We found that medicines were stored safely and managed appropriately. Each of the units stored their medication in a locked clinic room which was kept clean and tidy. The temperature of the room and the medication fridge was recorded daily to ensure it was within a safe limit. This is important as if medication is not stored at the correct temperature it may not work as effectively.

'Time sensitive' medications were given on time; this is important as if they are not given at the time they are prescribed, this can reduce the therapeutic effect of the medication. A relative told us, ''With their [relative's] condition, it's vital that they get their medicine on time and the staff here make sure that happens.''

Some people had covert medication plans in place so that medicines were disguised in food or drink without their knowledge. This meant that although the person refused to take their medication it was vital

for them to do so to preserve their well-being. We saw that this decision had been made with input from the GP and pharmacist and had been made in accordance with the person's best interests.

A medicine policy was in place to advise staff on the provider's medication policy procedures. Nationally recognized best guidance on the administration of medication was also available for referencing if required.

We looked at how controlled drugs were handled. We saw that controlled drugs were kept securely in a locked cupboard. Controlled drugs are subject to the Misuse of Drugs Act (1971) and associated legislation and so require extra checks. We checked the stock balances of a selection of controlled drugs and found them to be correct. The service performed a stock balance of controlled drugs twice a day. We found they had been signed out by two members of staff before being given in line with good practice.

Some people received PRN (as and when required) medication. We saw that protocols were in place to help ensure people received their medication when needed, for example pain killers. Whilst most people had PRN protocols in place, a minority did not. We discussed this with the manager who confirmed they would address this right away. For some people on PRN medication, such as sedatives, staff would attempt other techniques before giving the medication and would only give it as a last resort. This was good practice as it meant people not having to take medication unnecessarily.

The use of topical medicines such as creams and lotions were recorded appropriately with the use of body maps. This helped staff to apply topical medication to the correct part of the body.

For people with swallowing difficulties and who were prescribed thickening agent, this was recorded appropriately and staff were aware of how much thickener to add to people's fluids.

Care records showed good evidence of a range of risk assessments and tools used to help keep people safe. This included individual risk assessments for areas such as moving and handling, falls, choking and nutritional risks. Assessments were regularly reviewed and kept up to date.

The service was clean and odour free. Staff had access to personal protective equipment (PPE). This is equipment used to help reduce the spread of infection. We saw staff using disposable aprons throughout the day such as before mealtimes and whilst providing personal care. Regular audits were carried out in relation to infection control measures and any issues of concern were identified and acted on.

Systems were in place for monitoring environmental risk in the service. Firefighting equipment was maintained and people had a personal emergency evacuation plan (PEEP) in place. This meant that in an emergency situation people were likely to receive the support they required to evacuate the service. External contracts where in place for gas, electric, fire safety and legionella. Additional checks and audits were completed by the manager such as water temperature, automatic door closure devices, fire alarms and call bells. There were two full-time maintenance persons on site to help maintain the internal and external parts of the service.

We looked at accidents and incident reporting within the service and found they were recorded in sufficient detail and managed appropriately. They were reviewed by the manager and analysed for any trends or patterns. This helped the service to learn lessons from what had gone wrong and to help prevent this re-occurring in the future. This information was then used to further improve people's safety, for example, referrals to other health professionals or changes implemented to people's care plans and risk assessments.

Good

Is the service effective?

Our findings

People's support and health care needs were documented. Care records we saw contained information on how staff supported people with their dietary needs. Care records demonstrated that people were weighed regularly to ensure that people were not losing or gaining weight inappropriately. Staff we spoke with were aware of people's individual dietary requirements. We also spoke to the chef and kitchen staff who were aware of people's dietary needs.

The care records we looked at showed care plans which reflected both the health care needs of the person in addition to their personal preferences. For example, people could choose whether to have a bath, shower or a body wash and what time of day to have this. People could choose the gender of their care staff. Care records also contained detailed pre-admission reviews so that people's key health care requirements were identified and could met from the time they arrived at the service.

We saw that people were referred to external health care professionals appropriately, this included the GP, speech and language therapists, opticians, podiatrists, district nurses, physiotherapists and occupational therapists. This ensured that people's health needs were met and helped to preserve their overall wellbeing. For instance, one person's nutritional risk assessment showed they were at risk of choking due to swallowing difficulties, staff had made a referral to the Speech and Language Therapist (SALT) for advice. The person's care plan had been updated to incorporate the advice given by SALT.

Another care file showed that a person had been losing weight and so had been referred to the dietician, the person was then supported with a fortified diet by staff. This was good practice as it meant that staff were able to meet the individual health care needs of people living at the service. A relative of a person who lived at the service told us, ''If there's anything wrong, they always get the doctor. [The staff] will listen to you but they notice things themselves too and do something about it.''

People we spoke with told us they were offered a good choice of meals and that the menu changed on a monthly basis which helped to promote variety. We saw details recorded in people's care files about what foods they enjoyed most and how they liked their food presented for example, 'Loves sausages but dislikes eggs', 'Likes meat to be cut up into smaller pieces by staff'.

There were mixed reviews about the food; comments from people living at the service included, ''The foods nice but not always although I'm quite fussy about what I eat'', '' [The food's] lovely – like going out for a meal in a restaurant. I put on weight when I came here, I liked the food so much'', ''It's so-so most of the time.'' Comments from relatives included, ''They [relative] love the food here'', ''It's good and it can be bad'', ''They [relative] get enough and there's enough variety.''

We made observations during lunch and found that staff supported people well. Staff were patient in assisting people who required support and offered people choice. Staff also spoke regularly to people eating independently, for example by asking them if they wanted second helpings or had enjoyed their meal.

The daily menu was displayed on the wall of the dining room so that people knew what was on the menu for that day. The tables were nicely laid with tablecloths, napkins and vases of flowers in the centre. Condiments were also available. The dining room was arranged so there were several tables seating four which encouraged people to socialise over meals. For people who preferred to eat their meals in their bedrooms they could do so.

We looked to see if the service was working within the legal framework of the MCA (Mental Capacity Act 2005). The Mental Capacity Act 2005 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.

We looked at people's care records and saw evidence that people's capacity to consent was assessed appropriately in relation to a range of decisions. For example, people had consented to provision of care, use of bed rails and management of medication and had signed their own care plans. There were directions in care plans for staff to 'provide all of the information to the person so they can make informed choices.'

Where people are not able to consent, they can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at the care records for four people who had DoLS authorisations in place. We found there was an effective process to record any restrictions in the best interests of people living at the service. There was evidence of best interest decisions having been made with relatives input. For one person who had a DoLS application in process, we noted that some parts of their care records still referred to them as having capacity. We discussed this with the manager who informed us they would address this.

People we spoke with felt that staff had the knowledge and skills to meet people's needs. A person told us, ''The best thing is, the staff know what they're doing.'' A relative told us, ''I have no issues with staff skills.''

Records showed that staff members received appropriate supervision in their job role. The manager provided us with information on staff training. We saw that training was provided in a range of health and social care topics such as moving and handling, fire safety, first aid, safeguarding and cardio pulmonary resuscitation (CPR). Some staff had received training in more specialist areas such as dementia care and had completed external courses in care such as National Vocational Qualifications (NVQ). These qualifications were encouraged by the service.

Although all of the staff had completed mandatory training some staff had not updated this training. We discussed this with the training co-ordinator. They told us that gaps in training had already been identified and refresher training had been organised to take place in the next few weeks. Staff had recently been provided with their own login details to access training courses online. We saw that staff's induction training was based on the Care Certificate. The Care Certificate was introduced by the Government in 2015. This is a set of standards that social care and health workers comply with in their daily working life.

During our inspection we looked at people's bedrooms and saw evidence that people could personalise them. For example, some people had brought in their own items of furniture, others had framed family

pictures on the walls. One person had a small clock collection on display in their room.

The service was based on one level and so was easy for people to navigate. Communal corridors had handrails which contrasted against the colour of the walls making them visible. However, we did note that for the dementia care units the environment required further adaption to make it more dementia friendly. For example, better signage for bathrooms and bedroom doors to be painted different colours in order to better orientate people to their bedrooms. We have made a recommendation to the manager about this.

We saw that bathrooms had recently been refurbished and were spacious and modern and had bath, shower and wet room facilities.

Good

Is the service caring?

Our findings

People told us they were satisfied with the service and how well staff cared for them. One person told us, ''They are a good lot and do their best.'' Another said, ''Nothing is too much trouble and they know me by now.'' Comments from relatives included, ''They are well looked after'', ''The staff are very good with the people here. They stay calm and talk people down if they get a bit upset'' and ''The staff here know what [relative's] moods are and how to handle them. There's a low staff turnover, which I suppose says something about how they feel about working here too.''

We carried out a Short Observational Framework for Inspection (SOFI) to observe five people during the lunch time period. We found positive and warm interactions between staff and people living at service. We saw that people were treated respectfully and in a manner appropriate for their needs and level of independence.

We also observed the delivery of care at various points throughout the inspection and saw that staff provided care in line with people's preferences. We saw people were comfortable and relaxed with staff and it was clear that staff knew the needs of the people they were caring for well.

During our inspection we observed a person who was visibly upset. A member of staff acted upon this and began to sing the person's favourite song. The person began to sing along and became comforted and began to smile and laugh.

People appeared to feel safe and comfortable with staff when being supported. We observed one person being transferred from their wheelchair to an armchair by two members of staff, using a hoist. Staff reassured the person regularly throughout, explaining what they were about to do and checking the person was comfortable and relaxed.

Staff spoke to people using their names and took opportunities to talk to them when they could. For example, a carer who was completing records in the afternoon sat with a small group of people and sang with them whilst writing; this was clearly very much enjoyed by the group. A relative of told us, ''I know the quality of care [my relative] is getting and I'm quite happy. [The carers] don't just sit there, they talk to the people as well.''

On the first day of our inspection the weather was hot and sunny and we observed staff putting sun cream on people who wished to sit outside in the garden. Staff were seen to encourage people to take drinks during this time. A member of staff told us, ''We provided drinks [during the recent heat wave] every 15 minutes, or half hour or so throughout the day. I was thirsty so I knew [people living at the service] would be.'' Staff also knew the preferences of how people liked to take their hot drinks, for example tea with milk and two sugars.

We observed staff support people in a way that maintained their dignity. For example, staff would discreetly ask people if they required assistance by whispering in their ear. We also observed staff closing doors to

bathrooms and people's bedrooms when delivering personal care.

Staff encouraged people with their independence whilst providing discreet support. For example, we observed staff standing near to a person whilst they were mobilising with their walking frame.

People's preferences were respected, we observed a nurse returning to a person to give them their medication (as the person had been having their lunch the first time around) and had asked the nurse to come back.

Care records we looked at provided information on the most effective ways to communicate with people. For example, 'prefers to be told information in the morning when most alert', 'staff to speak slowly in a quiet environment' and 'communicates needs and wishes more effectively after breakfast'. For people who spent the majority of time in their bedrooms care records instructed staff 'to pop in to room when passing by to say hello.' One person had limited vision in one eye and there was guidance in the care plan for staff not to approach them from the affected side so as not to startle them.

Where people were unable to communicate verbally staff had adapted to this and used alternative methods of communication. For example, we witnessed a person rocking backwards and forwards in their chair, they were then taken to the toilet by staff. The person was not able to speak and ask for the toilet but staff had become familiar with the person's body language and so was able to meet their needs. Another person was unable to speak as a result of their medical condition so staff would interpret their eye movements and hand gestures to indicate 'yes' or 'no'. A word board was also used to help the person communicate what they wanted. This information was also recorded in people's care files for staff to interpret.

People told us the service had an open visiting policy so that relatives and friends could visit at any time. A relative told us, ''The open visiting hours works well, I come to see them [relative] in the day time and my sister comes after work.'' People told us this helped them to feel supported. Another relative told us how they had been allowed to stay overnight when their loved one had fallen ill. For people who had no family or friends to speak on their behalf, the service had details of an advocacy service. An advocacy service helps to ensure that the views and wishes of the person are heard.

We asked staff what equality and diversity meant to them, one told us, ''Everyone is equal, everyone is treated with respect and given choices as much as we can.''

Staff we spoke with told us they would regularly hold fund raising events to raise money to take people out or to buy toiletries for the people living at the service who had no relatives to purchase those things for them.

Good

Is the service responsive?

Our findings

We found that people's preferences in relation to how their care was delivered was recorded. This provided staff with information regarding the extent people wished to be involved with their care. Care records gave staff the information as to what people could do for themselves and what assistance they required. This helped to promote people's independence.

In all care records we found 'My Life, My Day, My Story' documents were in place. These were one-page profiles and provided information about the person such as the name they liked to be called, their life history, family members, childhood friends, memories, favourite holidays and former occupation. These documents helped staff get to know the people they cared for and to provide care based on people's individual preferences. In addition, 'My Day, My Life, My Details' documents were in place which set out people's medical history and health care needs.

Care records were maintained by staff who reviewed each person's care daily. We saw that appropriate care plans and risk assessments were in place and reviewed regularly. We saw that when there was a change in people's needs care plans were amended and updated. This meant that staff provided care and support based on people's current needs and preferences. For example, one person's care plan about their dietary needs provided staff with information about their medical condition and advice about what type of foods they should eat and why.

At the time of the inspection none of the people living at the service had specific requirements relating to their culture, sexuality or other protected characteristics. People told us that they could have access to a minister if required. A member of staff told us that in the past they had supported a person who was Muslim, the person was supported with their personal care and diet in a way that adhered to their belief and practices. A member of staff told us, ''All the people here have different needs and we know how to approach those needs.'' We did see a person with complex dietary requirements being given both physical and psychological support in relation to their condition, and that advice which had been provided by external professionals was carried out by care staff. This was good practice.

People told us they had been involved in the formulation of their care plan, one person told us, ''You can choose your own assistant [for personal care]. If you see they've put a man down [to assist] you have the choice and you can say you want one of the girls.'' We also saw that people were allocated a member of staff who became their 'key worker'. This helped to build relationships between the staff and the people they were caring for.

During our inspection we observed periods of time when people where sat in the lounge with either TV or music on in the background. Whilst people had a choice in what they wanted to watch or listen to, during these times there was little direct engagement with members of staff as they were busy attending to other tasks.

We spoke with the activities co-ordinators and were employed to develop and facilitate a range of activities.

There were three activity co-ordinators in total and they provided activities on each of the units. People could visit any of the other units if there were activities they wished to participate in. Activities on offer included sing along, bingo, arts and crafts, jigsaws and knit and natter. We were told that co-ordinators would engage in 'Meaningful Moments' with people and so engage in an activity which was significant to them. For example, one person had a passion for a local football club and although they could no longer attend any of the games, staff would talk to them about the football and any recent matches. A relative told us, ''The staff made kites with [relative] because that was an interest when they were younger and the staff knew that. They helped to make two and they're now in [relative's] room.'' There was also a 'pie and a pint' event, this was said to be enjoyed by the male residents in particular.

On the first day of our inspection we observed an activity being provided by one of the activity co-ordinators. The activity utilised memory prompting pictures and books and people were encouraged to talk about what they could see and what they remembered about the events being shown. One person told us, '' [The reminiscence activity] is working wonders for me. I love it from beginning to end.''

Sometimes people would enjoy activities from an external provider. A relative of a person living at the service told us, ''They have had animal therapy – people coming in with all sorts of different animals like snakes. There's an owl man too!''

Occasionally people went out on organised day trips. Staff we spoke with told us they had come in on their day off to take people out. One person had expressed an interest to take a trip out on a Liverpool ferry and they were supported to do this by staff. Another person who had a past expertise and interest in gardening was supported by staff taking them to assist the grounds person to maintain the garden areas; the person was also supported with regular visits outside of the service to attend to their own allotment with a friend.

People had access to a complaints procedure and those we spoke with knew help to make a complaint. One person told us, ''I would tell the staff if I wasn't happy about my care.'' A relative told us, ''I'd go straight to the manager [if there were any complaints].'' We looked at how complaints were managed and found there to be appropriate systems in place. The manager maintained a record of any complaints received and the actions taken to resolve them. The outcome of the investigation of complaints was also recorded.

We looked at processes in place to gather feedback from people and listen to their views. We saw that the manager sought feedback from people using the service and their relatives from quality assurance surveys and both resident's and relative's meetings. Feedback showed that the majority of people using the service felt 'happy and content', 'listened to', 'safe and secure', 'treated with dignity and respect' and 'treated as individuals'. Records showed that regular meetings took place with people living in the home and their relatives. A relative told us, ''We went to a meeting a while back – we had a phone call to invite us.''

At the time of the inspection, there was nobody receiving End of Life Care. We noted that people's end of life wishes were recorded in their care files if they felt comfortable to discuss the matter. "My Day, My life, My future" documents were used for this purpose and there was evidence of relatives' input. This contained information about whether the person wished to be resuscitated and 'Advanced Decisions' such as the person's wishes in relation to their final days.

Good

Is the service well-led?

Our findings

During our inspection we saw that audits were in place with regards to the safety of the environment, fire safety, infection control, care plans, accidents and incidents and medication. Audits we reviewed were up to date and identified areas where improvements were required. We saw that where actions had been identified these had been undertaken to improve the quality of the service provided. This demonstrated a clear process and showed that systems in place to monitor the quality of the service were effective.

The service had a 'turnaround' manager in post who had joined the service a few days prior to our inspection. The 'turnaround' manager acted as a temporary manager for the service until a new registered manager was recruited. People's feedback about the previous management of the home was positive. People we spoke with told us the previous registered manager was open and approachable and that they felt able to raise any issues or concerns with them. Comments from relatives of people using the service told us, ''Previous manager of the home was very hands-on, stayed late and was constantly on the unit, very approachable and interacted with the residents. We've not yet met the new manager'', ''We were glad [relative] came here, compared to other places we visited. If asked about a recommendation, we would recommend it here'', '' [Previous manager] was out and about all the time. You could always speak to them about anything.'' A member of staff told us, ''The previous manager was excellent and made some really positive changes, much of the recent refurbishment was down to them.''

The current temporary manager and the provider of the service intended to maintain the systems and processes put in place by the former registered manager until a new registered manager was appointed.

There were regular staff meetings which enabled staff to share their views and opinions. We looked at a selection of minutes which showed topics discussed included training, safeguarding, accidents and incidents, complaints and compliments. It was evident that best practice was promoted during these meetings and staff were encouraged to develop the service further, for example, by learning lessons from things that had gone wrong in the past.

There was a wide range of policies and procedures in place to guide staff in their roles. Topics included safeguarding, equality and diversity, infection control, whistleblowing, dignity and privacy, medication and end of life care. Staff we spoke with were aware of the home's whistleblowing policy and told us that they would not hesitate to raise any issues they had. Having a whistleblowing policy helps to promote an open and transparent culture within the service.

The manager had notified CQC of any events that had occurred in the home in accordance with our registration requirements. This meant that CQC were able to monitor information and risks regarding the service.

Ratings from the last inspection were displayed within the service as required. The provider's website also reflected the current rating for the service. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services,

and the public, with a clear statement about the quality and safety of care provided.