Sovereign Care (North East) Ltd

The Grange

Inspection report

Galbraith Terrace
Trimdon Grange
County Durham
TS29 6EG
Tel: 01207 502818
Website: www.sovereign-care.com

Date of inspection visit: 22 September 2015
Date of publication: 20/11/2015

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

The inspection took place on 22 September 2015 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We last inspected this service on 11 February 2014. The service was meeting all our regulatory standards at that time.

The Grange is a small care home in Trimdon Grange providing residential care for up to 17 adults with mental health needs. There were 16 people using the service when the inspection took place.

The service has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (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.

We found that there were sufficient numbers of staff on duty in order to meet the needs of people using the service. All staff were sufficiently trained or in core areas

Summary of findings

such as safeguarding, mental health, health and safety, medicines management and food hygiene. The registered manager was delivering care planning training during our inspection and we saw all future training had been mapped out via a training matrix. We found that staff were knowledgeable regarding people's needs, likes and dislikes.

The service had in place person-centred care plans for all people using the service and we found people who used the service and relatives were involved in their care planning. All care plans we saw were regularly reviewed. Consent for care was sought and the provider gained feedback through regular care reviews and residents' meetings, ensuring that people's voices were heard and their personal care, treatment and support needs were met.

People's preferences were considered and acted on with regard to meal options, personalisation of bedrooms and activities. We saw that people had been consulted and actively involved in the planning of the refurbishments in the home and the re-landscaping at the front of the property.

A respect for independence and individuality underpinned management and staff behaviours, as well as the Service User Guide, a copy of which was in each person's room. This was also available in easy-read formats. We observed patient and thoughtful interactions by staff during our inspection and a range of people who used the service, relatives and healthcare professionals also told us that people were treated with dignity and respect.

There were effective pre-employment checks of staff in place and robust supervision and appraisal processes.

Transition between services was managed well, with a number of people who were new to the service speaking positively about their experience, as well as healthcare professionals and relatives. We also saw that the service had supported a number of people to move on from the service into a supported living environment.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. All staff we spoke with were knowledgeable on the subject of DoLS and the registered manager had provided appropriate paperwork to the local authority to deprive people of their liberty, where it was in their best interests. We saw that fingerprint recognition technology had been installed to support the implementation of DoLS, meaning people who were not subject to such safeguards could easily leave the premises.

The service had robust risk assessments, policies and procedures in place to deal with a range of eventualities, as well as a comprehensive set of audits in place. We saw these processes were reviewed regularly.

All people we spoke with agreed the service was managed effectively.

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?

Good

The service was safe.

People told us they felt safe at The Grange.

Risk assessments were individualised, regularly reviewed and staff had a good knowledge of the risks presented to people and how to manage these risks.

Safeguarding training had been undertaken and all staff we spoke with had a clear understanding of risks to individuals and actions they would take in the event of identifying such risks.

Medicines management and administration was well managed, with staff trained and supervised appropriately. Where suggestions were made to improve the safety of medicines administration, the service acted promptly.

Is the service effective?

Good

The service was effective.

Staff members were supported through a range of mandatory training which was effectively monitored and updated using a training matrix.

People were supported by knowledgeable staff to maintain good health through individualised plans and external specialist involvement.

The registered manager and all staff we spoke with had a good understanding of the DoLS, as part of the Mental Capacity Act 2005. The use of fingerprint recognition technology on external doors was an innovative solution that balanced the need to safeguard some people without negatively impacting on the freedoms of others.

Is the service caring?

Good

The service was caring.

Respect for independence and diversity underpinned the interactions between staff and people using the service and we observed a range of compassionate interactions during our inspection visit.

People were involved in and understood their own care through, for example, pictorial explanations of care plans in their care file.

Through the involvement of people, relatives, and relevant healthcare professionals and with reference to industry best practice, the service provided a dignified and compassionate approach to end of life care.

Is the service responsive?

Good

The service was responsive.

We saw evidence of advice being sought promptly from external specialists where staff noted health risks to people using the service.

Summary of findings

The service sought and acted on feedback from people using the service and their relatives through regular involvement in care reviews and meetings.

The service effectively and compassionately managed the transition of people moving to the service, ensuring they were made to feel welcome and their care needs met.

Is the service well-led?

Good

The service was extremely well-led.

The registered manager had a comprehensive knowledge of, and contributed to, the day-to-day running of the service. They took personal responsibility for exploring and implementing procedures that had a positive impact on people who used the service, such as the sourcing of fingerprint recognition technology and comprehensive pre-assessment processes designed to welcome people to the service.

The values of respect, dignity and independence, as set out in the service user guide and statement of purpose, were held consistently by all staff we spoke with. All staff told us they received timely and comprehensive support from the registered manager.

The registered manager was very supportive towards staff and sensitive to their needs. The registered manager had formed and maintained extremely positive working relationships with a range of external healthcare professionals, which contributed to people using the service feeling assured that they received a high standard of care.

The Grange

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.

We visited the service on 22 September 2015 and the inspection was unannounced. This meant the provider or staff did not know about our inspection visit. The members of the inspection team consisted of one Adult Social Care Inspector and one Specialist Advisor. A Specialist Advisor is someone who has professional experience of this type of care service.

We spent time observing and speaking with people in various areas of the service including the dining room, lounge and kitchen areas.

A member of staff showed us the rest of the premises including bedrooms, bathrooms and the outdoor spaces.

On the day we visited we spoke with six people who used the service. We also spoke with the registered manager, the senior carer, two other members of care staff and the cleaner. Following the inspection we also telephoned and spoke with two relatives, three healthcare professionals and a commissioning professional. No concerns were raised by these professionals.

During the inspection visit we looked at four people's care plans, staff training and recruitment files, a selection of the home's policies and procedures, quality control and audit procedures and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the Care Quality Commission.

Before the inspection we did not ask the provider to complete a Provider Information Return (PIR). During this inspection we asked the provider to give some key information about the service, what the service does well, the challenges it faced and any improvements they planned to make.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. One person said "I felt safe from day one of coming here," whilst a relative we spoke with told us there were "No concerns or problems on that front." Similarly, all healthcare professionals we spoke with stated that they had never experienced concerns regarding the safety of the service.

We saw that people using the service had individualised risk plans in place. For example, we saw one person's preferred activity was to visit a pub near their previous home on a regular basis. We saw that a specific risk assessment was in place. This incorporated other aspects of care plans and risk assessments to ensure any risks associated with this activity were identified and managed. This meant the service managed risks without impacting on people's freedom and choices.

All people using the service had a range of risk assessments in place, tailored to their needs, which were robustly documented. When we spoke with staff they were able to give detailed responses to the risks individuals faced and how they managed these. This meant people were protected from avoidable risks through early identification and mitigation of such risks.

We saw the provider had suitable arrangements in place for storing and administering medicines and that for the most part these were implemented. We saw that Medication Administration Record (MAR) sheets were signed after each administration of medicines and witnessed by a second member of staff. We reviewed a sample of these MAR sheets and found no errors. Where people had medicines 'as required' there were protocols in place to monitor how regularly people were having these. We saw reviews regularly took place with the GP. Staff had a sound knowledge of which people needed medication at a defined time and we saw that staff competence regarding the administration of medicines was reviewed regularly. We observed a Senior Care Worker administering medication and they adhered to best practice as set out by the National Institute for Health and Care Excellence (NICE). This meant people were protected against the risk of unsafe medicines administration.

We saw that one person whose MAR indicated medicine administration at 'breakfast time' often did not arise from bed until later in the morning. The registered manager agreed to request a change to the prescription with other healthcare professionals to ensure the timing of medicines administration was tailored to the person's preferences. We observed that this had been put in place on the day of the inspection.

Medicines that required refrigeration were kept separately in a designated refrigerator but this was not suitable. The fridge was difficult to access, not lockable and the freezer box was impacted with ice. We raised these issues with the registered manager who was able to show us that they were regularly checking the fridge temperature. They also acknowledged the shortfalls of the refrigerator and began sourcing a replacement on the day of the inspection. This meant that, when an aspect of medicines storage was highlighted as not being in line with established best practice, the registered manager made prompt and effective changes. This ensured that people who used the service were protected against the risk of unsafe medicine storage.

We spoke to three members of staff about their experience of safeguarding training and all were able to articulate a range of abuses and potential risks to people using the service, as well as their prospective actions to take should they have such concerns. This demonstrated that training had been effective in that staff knew how to recognise and respond to safeguarding situations.

All staff we spoke to felt staffing levels were appropriate and all people we spoke to who used the service, relatives and healthcare professionals felt there were sufficient staff to meet the needs of people. One member of staff told us, "Sometimes we are rushed but we pull together," whilst another said, "The manager ensures that there are enough staff to look after the residents and do the cooking." One relative told us, "Staff are pushed" in terms of their workload but that this never negatively impacted on the care the person who used the service received. This meant staffing levels and teamwork supported people to receive timely and appropriate care.

We reviewed a range of staff records and saw that all staff underwent pre-employment checks including enhanced Criminal Records Bureau (now the Disclosure and Barring Service) checks. We also saw that the manager verified at least two references and ensured proof of identity was provided by prospective employees' prior to employment.

Good

Is the service safe?

This meant that the service had in place a robust approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

Incidents and accidents were accurately recorded and we saw that each was analysed and corrective actions put in place.

All communal areas, bedrooms, bathrooms and the kitchen were clean. The Food Standard Agency (FSA) had given the home a 5 out of 5 hygiene rating, meaning hygiene standards with regard to food preparation were "very good". We also saw that all staff had been trained in Food Hygiene. This meant that people were protected from the risk of acquired infections.

Maintenance records showed that Portable Appliance Testing (PAT) was undertaken recently and a five-year electrical inspection was planned. There was documentation evidencing the servicing and maintenance of all equipment in the home. This meant people were prevented from undue risk through poor maintenance and upkeep of systems within the service.

We saw that fire extinguishers had been checked recently and fire maintenance checks and emergency lighting tests were in date, along with regular fire drills. We saw Personalised Emergency Evacuation Plans (PEEPS) were in place, meaning that people could be supported to exit the building by someone who would have access to their individual mobility and communication needs in the event of an emergency. This meant the service was helping to protect people using the service from risks brought about through fire or accident.

Good

Is the service effective?

Our findings

All people who used the service told us they had confidence in the abilities and knowledge of staff. Relatives felt likewise and we saw the following comments in the visitor book: "Extremely impressed with the level of professionalism," and "Staff always follow care plans and go above and beyond." One healthcare professional we spoke with said they thought the staff show "Really good knowledge of people and they communicate it well." This meant people were assured of receiving effective care from staff who were suitably knowledgeable about their individual needs and preferences.

Staff training covered the provider's mandatory training such as safeguarding, mental health awareness, manual handling, first aid, infection control, fire safety and health and safety. This meant that staff had the knowledge and skills to carry out their role and provide high levels of care to people using the service.

We also saw a member of staff in a non-caring role had received mandatory training to ensure, whilst working in the care environment, they had regard to and knowledge of, for example, mental health needs. The registered manager was delivering care planning training during our inspection and we saw all future training had been mapped out via a training matrix. We saw that Care Certificate documentation was in place and would be used when new members of staff joined the service. Members of staff we spoke with told us they had felt supported through the induction programme, which had consisted of training and shadowing an experienced member of staff. This meant the provider was committed to the continuous development of staff, which in turn ensured people using the service could continue to expect high levels of care.

We saw care was provided with people's consent. This was clear in people's care plans, in conversations we had with people and their relatives, and through our observations. For example, we saw one person being treated for an eye condition. The member of staff checked that the person was happy with the care being given and that the person consented before moving from one eye to the other eye. This meant the need for consent was upheld and respected in day-to-day interactions as well as documented in care plans.

We also saw that consent was embedded throughout care planning. For example, people's sleep care plan made it clear that it was each individual's choice when they went to bed and got up and that this choice should be encouraged. This meant documentation as well as staff attitudes contributed to the encouragement of independence and choice.

Information provided to people regarding their care was sometimes communicated with the aid of pictures. For example, glasses and denture care plans, meaning people could more easily understand the care they received.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Where that freedom is restricted a good understanding of DoLS ensures that any restrictions are in the best interests of people who do not have the capacity to make such a decision at that time. We saw that members of staff had been trained on the subject of Mental Capacity recently and, when we spoke with various members of staff they were able to explain the practicalities of the legislation and demonstrated a good knowledge of how DoLS impacted on people's lives. The registered manager was knowledgeable on the subject of DoLS and had submitted appropriate applications to the local authority. They had installed fingerprint recognition technology on external doors, meaning that people not subject to a DoLS could press their finger against the lock to leave, whereas people subject to a DoLS could not leave the premises without support. This meant the service balanced the need to safeguard some people without negatively impacting on the freedoms of others.

People told us that they enjoyed the food at the home and we observed people being offered a choice of meals via a menu on a four-weekly cycle. We saw that the service had literature relating to a Malnutrition Universal Screening Tool (MUST) but had yet to implement it. MUST is a screening tool using people's weight and height to identify their body mass index for those at risk of malnutrition. We therefore reviewed the service's systems for monitoring and managing weight loss and found them to be effective, with

Good

Is the service effective?

people being weighed monthly and, where there were concerns, more regularly and with dietician involvement. This meant people were protected against the risk of malnutrition and given a nutritious, balanced diet.

We found there was evidence that people were supported to maintain health through accessing healthcare such as opticians, podiatrists, occupational therapy, speech and language therapy, GP appointments and District Nurse visits.

We saw that staff supervisions were undertaken monthly along with an annual appraisal. When we spoke with staff, they felt supported by this process and felt there was ample opportunity to identify any training needs or concerns themselves. This meant people could be assured they were cared for by staff who regularly had the opportunity to challenge practices as well as access resources to improve their skills.

We saw that a person who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place had been fully involved in the decision, as had family members and local medical professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. This meant people were involved in regularly monitoring their needs.

Good

Is the service caring?

Our findings

One person who used the service stated, "I like being here and get respect from the staff". Another said, "The staff are lovely and I am happy being here and if I had a complaint I would be able to make one and it would be dealt with." This experience of dignified and compassionate care was supported by relatives, one of whom said the staff, "Bend over backwards to help," whilst another told us, "The staff are brilliant and friendly." Health and social care professionals were in agreement about the positivity of care provided. One told us, "The staff are always compassionate."

One visiting training professional also stated that people "Are always treated with dignity and respect." We observed people's privacy and dignity was respected and supported. For example, during our inspection we asked to observe medicines practices. A member of staff asked people who used the service whether they were comfortable with this before continuing with medicines administration. This meant that people's dignity was considered before treatment was given.

We consistently observed patient, caring and compassionate interactions between staff and people using the service throughout our visit. There was warmth and humour in the relationships staff had developed with those they cared for, informed by knowledge of people's personal histories, likes and dislikes. Following the inspection visit we spoke with relatives of people who used the service and healthcare professionals who also stated people were cared for in a compassionate manner.

The service was providing end of life care to one person at the time of our inspection. Relevant healthcare professionals and family members told us they had been involved at all stages of planning and review and that the care was "Very caring and compassionate."

All care plans were reviewed regularly with the involvement of people who used the service and we saw that some care plans had been written in such a way as to encourage people who take part in their own care. For example, there were denture care plans in place with step-by-step pictorial guides so that people could maintain their own dentures. We saw similar plans for glasses and dental care. This meant that, where practicable, people were able to contribute to aspects of their own care through thoughtful and accessible care planning, which also promoted independence.

We saw that staff held one-to-one meetings with people using the service to seek their views on care being provided and how it could be improved. In addition to individual meetings with people using the service, we also found the provider held group meetings as a means of gathering preferences and addressing any wider ongoing concerns. This meant people were given a voice as individuals and as a group to contribute to their own wellbeing and the management of the service.

We saw the service had a confidentiality policy in place and that people's personal sensitive information was securely stored, meaning people's confidential information was protected.

Nobody who used the service was currently using an advocate but we saw that information on advocacy was available in each person's room in an easy to read format, as well as being in the Statement of Purpose. One healthcare professional also told us "Staff are pro-active in advocating for residents". This meant that the service ensured there were a range of measures in place to support people who used the service to have their views represented.

A priest from a local church visited the service once a week to provide support to anyone who wanted it and the service offered an escort service to places of worship if requested from people. This meant that people's religious preferences were respected and supported.

Good

Is the service responsive?

Our findings

The service had in place a range of systems to ensure people received personalised, responsive care. For example, the provider held regular group meetings with people using the service to ensure activities were meeting their needs. At this forum we saw that people who used the service had recently suggested various trips to the coast, the hiring of a 'party bus', an animal sanctuary visit and other activities. We saw that these requests had been facilitated and people told us they had enjoyed these activities, meaning they were partaking in activities meaningful to them and also being protected against the risk of social isolation. We also saw these meetings were used as a means of involving people in the ongoing refurbishment of the service. For example, people's preferences had been acted on when repainting the living room. Feedback was sought at the subsequent meeting to ensure that people were happy with the outcome. We saw that people had confirmed they were happy with the redecoration. This meant that the service sought the views of people who used the service, acted on those views, and then reviewed whether the outcomes were satisfactory for people.

We saw a range of positive outcomes for people who used the service through the responsive approach to care. For example, we saw that one person who had moved to the service with significant mobility problems had been encouraged to move independently wherever possible. One healthcare professional noted "[Person] did not need a wheelchair today but mobilised independently, which was a great improvement." We saw that another person had suffered significant weight loss and that the service had put in place, through liaison with a dietician, a detailed nutritional plan that had ensured the person regained the weight lost and was able to put on weight. This meant the service brought about positive changes to the health and wellbeing of people who used the service through the regular review of care and liaison with external healthcare professionals.

The service had a complaints policy in place and we saw that, where a complaint had been made, the registered manager had responded to the complaint in line with the policy and reached an outcome that was satisfactory to the person who used the service. People who used the service told us they were happy they knew how to raise concerns if they had them and we saw the Service User guide section on complaints was supported by explanatory pictures. This meant people were informed and supported to challenge aspects of care if they felt the need to.

We reviewed four care plans of people using the service and saw evidence of people and their relatives involved in regular reviews of their care plan, as well as being regularly consulted when needs changed. The service also ensured a broad range of input from external healthcare professionals to ensure people's care plans were accurate. For example, the GP, district nurse, speech and language therapy, specialist mental health professionals, podiatry and dieticians.

Personalisation of care was set out as a key aim in the Statement of Purpose and we saw staff having regard for people's changing personal needs both in the content of care planning reviews and in a shift handover we observed, where all members of staff displayed in depth knowledge of people's needs, not just the person to whom they were the designated keyworker. Likewise, one healthcare professional told us "They are responsive to [Person's] fluctuating needs."

Care plans were easy to follow for members of staff but also for people who used the service and each individual care plan was supported by a risk assessment, both of which were reviewed monthly with the involvement of the person.

We saw that there was an inclusive approach to the re-landscaping work at the front of the service, where a tarmac area had been replaced with a lawn and plants. We saw that people who used the service had been asked for their ideas about how the area should look, and that these ideas had been incorporated by the service. Likewise we saw people who used the service had been consulted as part of regular residents' meetings about prospective refurbishment s to the service.

We looked at the service's approach to managing people's transition between services and found it to be excellent. For example, one person's care co-ordinator told us that improvements to the person's wellbeing since moving to the service had been enabled through the "Trust and rapport" the service builds with people. They stated that the emphasis was on promoting independence "From day one" and described the improvement in the person's wellbeing as a "Massive Achievement." They confirmed that the registered manager had visited the person prior to their

Good

Is the service responsive?

move in order to understand their preferences. This approach by the registered manager was consistent with the admissions process as set out in the Statement of Purpose, which clearly sets out how the service should welcome a new person, from their preferred name to dietary requirements. This meant people new to the service were assured of a dedicated, person-centred welcome that was as homely as possible with a view to minimising anxiety and making transition as smooth as possible.

With regard to potential emergency transition between services we saw that everyone using the service had a hospital administration sheet in place. This documented essential information to be used if a person was admitted to hospital. This meant that people could be assured a more consistent, co-ordinated approach to their care should they have to move between services.

Good

Is the service well-led?

Our findings

At the time of our inspection, the home had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had been at the service for six years.

One visiting social worker had written in the visitors' comments book "The support the registered manager provides to their staff and more importantly the service users is to a high standard." All people we spoke with, including relatives and healthcare professionals, were highly complimentary about the management of the service and the atmosphere in the home. One healthcare professional said "They're absolutely fantastic", whilst a relative told us "I can't fault their approach and the way they follow things up."

During the inspection we asked for a variety of documents to be made accessible to us during our inspection. These were promptly provided, well maintained and organised in a structured way, making information easy to find. The management of documentation was such that key policies and procedures were clearly accessible for any member of staff. We found the registered manager maintained up to date and accurate records.

The registered manager was clear about the values set out in the Service User's Charter and the staff code of conduct and was responsible for ensuring those values were held consistently by staff. They said, "We never give up on anyone" and we saw evidence of improvements in the health and wellbeing of a number of people with significant health problems. All staff we spoke with referenced as integral the registered manager's "Hands-on" support and influence in achieving these outcomes. This meant that people were supported by staff holding a consistent and clear set of person-centred values.

The registered manager was aware of and part of the day to day culture of the home, which was one of warm mutual interactions between staff and people who used the service, and clear, open communication. The registered manager had therefore developed a strong understanding of and rapport with people who used the service. We saw that, when a person who used the service had died, the registered manager came into the service on the Sunday in order that the news could be broken as sensitively as possible. They offered additional support to people who used the service and bereavement counselling was provided to staff. This meant the registered manager had a strong sense of a duty of emotional care to people who used the service and to staff.

The registered manager took personal responsibility for visiting prospective residents to ensure they were welcomed to the service before arrival. The registered manager was also involved at all stages of new admissions, including introducing people to other people who used the service and, for example, taking them out for a coffee to begin building a rapport. This meant the registered manager ensured that every person who used the service received a personal and homely welcome. One healthcare professional confirmed this personal approach, stating, "[registered manager] made what could have been a tense and uncertain transition into respite care very easy with her extra friendly and caring manner."

We saw the registered manager also took responsibility for supporting four people into supported living recently, meaning the service was able to deliver another of its key aims, to support people wishing to move out of residential care. This demonstrated that the registered manager had regard to people's human rights by actively promoting the right to a private life and enabling people to fulfil that right to a less restrictive environment.

The registered manager showed us the staff rota and kept staffing levels under review on a regular basis and adjusted levels according to people's needs and activities. We saw that the chef had recently unexpectedly resigned and that the registered manager had discussed this issue with all staff at a meeting before agreeing a short-term contingency of care staff preparing meals. All staff had been trained in food hygiene, which meant people who used the service were not negatively impacted by the departure of the chef. This demonstrated how positive teamwork was prevalent within the service.

Continuous professional development was supported by the registered manager and we saw that they had ensured everyone working in the home, including those with non-care related responsibilities such as cleaning, were included in the roll-out of mandatory training such as mental health awareness. We spoke to one person in a non-care role who told us, "I saw it was important to have the background knowledge if you're working here." They also went on to particularly commend the support received from the registered manager in completing these and other

Good

Is the service well-led?

training courses, stating, "If it wasn't for working here and doing these courses I wouldn't have branched out." This meant that the registered manager valued staff and supported them to gain the necessary skills to carry out their duties but also to pursue training that could support their professional development in the health and social care sector.

We saw that policies and procedures, which the registered manager effectively reviewed and updated, were informed by current thinking, research and practice. For example, National Institute for Clinical Excellence [NICE] guidance informed medicines administrations, whilst end of life care planning and implementation was informed by use of Gold Standards Framework guidance [Gold Standards Framework is a nationally recognised training and accreditation programme with the aim of improving end of life care]. This meant the registered manager was aware of best practice and ensured improvements to care were made in light of that practice. We also saw that all staff had signed as read the newest version of policies and procedures. This meant the registered manager ensured that all staff were aware of all established practices within the service.

We saw the registered manager carried out a range of audits and spot checks. These included checks on the cleanliness of the service, including the kitchen, medicines, fire equipment and general environmental checks weekly. We saw that these had recently identified the need to repaint areas of the home and, for example, take down and wash curtains. We saw that the majority of identified actions had been completed. We saw that not all recommendations had yet been implemented. For example, replacing the hall table had been noted as an action for a number of months. When we asked the registered manager about this they acknowledged that some of the pending actions had not yet taken place but were able to show us that they had recently employed a handyman. We reviewed the handyman's log book and saw that a number of identified actions had been completed each day. We checked these references against the areas noted, for example checking that tiles noted as replaced were indeed replaced and that repainting had taken place. This meant the registered manager took responsibility for assuring the quality of the service and the premises and, where shortfalls were identified, put in place measures to correct them.

The registered manager had recently distributed staff and resident surveys, the majority of which were returned with wholly positive comments regarding all key areas of the service. The survey responses attested to the support and approachability offered by the registered manager. We saw a range of similar positive comments had been made in the visitor's book. These surveys, alongside the meetings and reviews noted above involving people who used the service, meant the service was actively involving a broad spectrum of people through a range of means in the development of the service.

Feedback forms for an independent online care home information service were also readily available in the entrance hall. We reviewed the feedback and found only positive comments. This meant that the registered manager ensured a range of feedback methods were used to liaise with people using the service, their friends and family, and staff, meaning that the service promoted a positive, open and transparent culture.

We found the leadership, management and governance of the service to be very good.