Dryclough Manor Limited

Dryclough Manor

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 of Dryclough Manor. We last inspected the home in January 2014. At that inspection, we found the service was meeting all the regulations that we reviewed.

Dryclough Manor is a purpose built two-storey care home. Set in its own well-maintained grounds the home can provide accommodation for up to 42 people who require nursing and personal care. At the time of our inspection there were 38 people living at Dryclough Manor. All bedrooms had ensuite facilities.

The home had a manager registered with the Care Quality Commission (CQC) who was present on the day of the inspection. 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 and associated regulations about how the service is run.

We saw that Dryclough Manor was clean and well maintained, Access to the building was secure and staff understood how to protect people living at the home from different forms of abuse. The service had whistleblowing and safeguarding policies that staff could access and staff were aware of their responsibilities to report any untoward behaviour they might witness.

People were supported by a stable staff team who had worked together for a number of years and knew the people who used the service well. We saw that there were enough staff and people told us that the staffing ratio reflected the needs of the residents.

Care records gave a good indication of people's abilities and provided a good description of their individual likes and dislikes. Where risk had been identified, risk plans were in place to minimise the risk of harm occurring. Senior staff were trained to administer medicines and we saw procedures were in place to ensure the safe management of medicines. We were told that no medicine errors had been reported in the last twelve months.

The people who used the service and their visitors told us they believed the staff were competent and knowledgeable. We saw from looking at the training records that staff received appropriate training to meet the identified needs of people who lived at Dryclough Manor, such as dementia training, capacity and consent, dignity and respect and end of life care.

Staff communicated well with each other and we saw that information was exchanged between staff informally throughout the working day, and a detailed handover meeting took place at the start and finish of every shift. This ensured that care staff were aware of any change in people's care needs and of any tasks which might need to be completed.

The registered manager and the care staff we spoke with demonstrated a good understanding of capacity and consent. When people were being deprived of their liberty the correct processes had been followed to

ensure that this was done within the current legislation.

Attention was paid to people's diet and people were supported to eat and drink in a way that met their needs. We saw that the food was good and that people had enough to eat and drink.

Care staff at Dryclough Manor monitored people's general health, and where specific healthcare needs were identified the service was proactive in seeking the right level of support; liaising with health care professionals, such as general practitioners (GPs), District Nurses and physiotherapists to provide an appropriate level of support.

We saw people were comfortable and looked well cared for. Staff were vigilant to people's needs and were able to respond in a timely way to people's requests for assistance. They respected people's need for privacy, but understood the risk of social isolation and did not leave people unattended. Staff spent time talking with people on a one to one basis or in small groups so that people felt like they were included. A person who used the service said to us, "The staff always look after us and check we are OK, or they will leave us alone if we need peace and quiet, they respect that".

Relatives informed us that they were listened to, and felt comfortable speaking to any of the staff if they had any concerns.

The home had a registered manager who was respected by staff, residents and their relatives, and had a visible presence throughout the home.

To help ensure that people received safe and effective care, systems were in place to monitor the quality of the service provided and there were systems in place for receiving, handling and responding appropriately to complaints.

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

Risks were identified and appropriate action was taken to reduce the risk.

Staff were recruited safely and there were sufficient well-trained staff to meet the needs of people who used the service.

A safe system of medicine management was in place.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and appraisal.

Staff showed an understanding of capacity and consent issues. Where people were being deprived of their liberty the registered manager had taken the necessary action to ensure that people's rights were considered and protected.

Attention was paid to what people ate and drank, and care was taken to ensure people were supported with their nutritional needs.

People had good access to healthcare and their physical and mental health needs were monitored by staff.

Is the service caring?

Good

The service was caring.

Staff had an in-depth knowledge and understanding of the needs of the people who lived at Dryclough Manor and provided care in a patient and friendly manner.

Staff were vigilant to need and were able to respond in a timely way to people's requests for assistance.

Privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People told us the care staff responded promptly to their needs.

The service had systems in place for receiving, handling and responding appropriately to complaints,

Care records contained detailed information about people and how they liked their care to be delivered.

Where possible, people were encouraged to voice their opinions about the quality of their service, and their views were taken into consideration.

Is the service well-led?

Good

The service was well led.

The service had a manager registered with the Care Quality Commission (CQC) who was held in high regard by staff and residents.

Systems were in place to assess and monitor the quality of service provision.

The registered manager understood their legal obligation to inform CQC of any incidents that had occurred at the service.

Dryclough Manor

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 1 September 2016 and was unannounced. The inspection team consisted of one inspector.

Prior to the inspection we reviewed information we held about the service, including notifications the CQC had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us without delay. We also reviewed the inspection report from the previous inspection and reviewed information submitted to us by the provider in the 'provider information return (PIR). This document asks the provider to give us some key information about the service, what the service does well, and any improvements they are planning to make.

During our inspection we spent time in communal areas observing how people were being cared for and supported. We spoke with four people who used the service and three visiting relatives.
We spoke with the registered manager, the assistant manager, two members of care staff, the cook, and a member of housekeeping staff.

As part of the inspection we reviewed the care records of four people who used the service and records of three people relating to the administration of medicines. In addition we looked at arrange of records concerning the management of the service, these included two staff personnel files, training records and quality assurance systems.

Good

Is the service safe?

Our findings

People told us that they felt safe at Dryclough Manor. One person who used the service said to us, "It is very, very safe. That is a reason for staying, that, and it is so pleasant." A visitor remarked that she worried about their relative before they chose to live at Dryclough Manor, but now, "I have peace of mind, and I know [XX] is safe here."

We saw that the home was secure. The entrance was kept locked; to gain entrance visitors had to ring the doorbell and an intercom system with camera allowed staff to check the identity of any visitor before allowing access. This ensured that unauthorised people would have difficulty entering the home. Staff and people who used the service with capacity were able to get in and out of the building and access the outdoor area freely, using a key code.

At work stations staff had access to a computerised suite of up to date policies and procedures, including the agency's Safeguarding Adults policy. This which provided guidance on their responsibilities to protect vulnerable adults from abuse. The staff we spoke to told us that they were aware of these procedures and demonstrated a good understanding of different types of potential abuse, and a thorough understanding of the signs and symptoms that may indicate abuse. One staff member told us that they remained on their guard for any changes in character, mood or behaviour, which might indicate abuse. Similarly, the staff we spoke to were aware of the provider's whistleblowing policy. ,

We looked four care records which showed that risks to people's health and well-being had been identified. These involved risks such as mobility, eating and drinking, nutrition and hydration, communication and hygiene. We saw that where risk had been identified as high or moderate a corresponding detailed care plan was put into place to help reduce or eliminate the identified risks and reviewed on a regular basis. However, we noticed that the information recorded in risk assessments did not always correspond to the most up to date information available. For example, one risk assessment regarding nutrition did not reflect the preventative measures already put into place to minimise the risk. When we pointed this out to the registered manager they checked and updated the records. Another risk assessment identified a high risk of falls. Steps identified to minimise the risk had been effective, and records showed that the person had not had a fall in the past twelve months.
When we looked around the home we saw that steps had been taken to prevent injury or harm, for example, crash mats next to beds so if a person were to roll out of bed the risk of injury would be reduced, and call bells were accessible to allow people who used the service to summon help.

We found systems were in place in the event of an emergency. There was a fire risk assessment in place and we saw that personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs. The service also had a business continuity plan in place. The plan contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or utility failures.

We saw the registered manager held health and safety meetings on a three monthly basis. We saw the home employed a full time maintenance officer, who ensured that health and safety risk assessments were completed in a timely manner, and records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, portable appliance testing, fire detection and emergency lighting. This helps to ensure the safety and well-being of everybody living, working and visiting the home.

We looked around all areas of the home, and saw that it was well maintained. Outside there was a secure and accessible garden and people we spoke to who used the service told us that they us they enjoyed walks in the garden. There was also a small patio leading off one of the lounges where people could sit out in good weather. Bedrooms, dining rooms, and lounges were clean and warm, but we noticed that bathrooms and communal toilets were not always tidy, for example, stacks of towels were stored on bath chairs. When we spoke to the registered manager she agreed that this was not appropriate and agreed to remove them. Communal areas were kept clear of obstacles to minimise the risk of accidents, although we saw that at meal times the dining room became fairly crowded, with little space between tables. This was acknowledged by the registered manager, and we were informed that there were plans in place to build a further 'sun lounge' to provide further space for people who used the service. We noticed that corridors and walkways were generally kept free of any clutter, but we noticed that there were a number of large items in recesses and obstructing a service lift on the first floor, such as unused laundry baskets and frames. The registered manger agreed to have these removed to an upstairs attic storeroom where they would be out of harm's way.

There was lift access and two flights of stairs to the upper floor. The main stairway was wide with shallow steps. A second stairway was secured with a safety gate on the first floor landing to prevent risk of people falling down the stairs. We saw that where dangerous or hazardous equipment was stored doors displayed warning signs and 'keep locked notices'. When we tried these doors we found that they were locked.

We saw bathrooms were pleasantly decorated to ensure that bathing would be a more pleasurable experience. Baths were equipped with temperature controls and bath chairs to help people get in and out. Communal toilets were well equipped. Soap, paper towels, disposable aprons and hand gel were available. Pedal bins with appropriate colour coded bin liners further reduced the risk of cross contamination.

An established staff team supported people who lived at Dryclough Manor. The registered manager told us that the last person recruited (a member of kitchen staff) had been selected more than eighteen months previously and the care team had been consistent for over two years. This meant that people were cared for by staff who knew them well. We looked at the recruitment procedures which gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of people living at Dryclough Manor. We looked at two staff files. These contained proof of identity, and a current photograph; an application form that documented a full employment history and accounts for any gaps in employment, interview notes, a job description, and two references. Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work, and these checks were updated every three years. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed at Dryclough Manor.

When we reviewed staff files, we saw an instance where issues of poor conduct had been raised with the registered manager. Appropriate disciplinary processes had been followed, including verbal warnings, and, proportionate action had been taken to reduce the risk, including retraining and close monitoring and supervision.

We saw that there was a good ratio of staff to people who used the service. The registered manager informed us that they used a dependency tool to determine how many staff would be required. There were generally six care staff on duty during day with three waking night staff, who began work at 8:00 p.m. and finished at 8:00 a.m. There was some flexibility should needs change, for example, if more staff were needed due to illness of people who used the service or end of life care. In addition, the registered manager and assistant manager operated a 24 hour on call system. We looked at the staff roster, which was planned in advance, with little need to seek extra support. We were told that any sickness was generally covered by regular staff, who would be paid overtime, or the service also had two 'bank' staff who could be employed on a shift by shift basis. The registered manager told us that they had never had to use agency staff and believed familiarity with people who used the service was important.

We asked staff if they felt there were sufficient numbers, and they agreed that there were; one told us that, "There's always someone around and we all muck in to help each other. It used to be every person for themselves, but it's no longer like that. We realised that if we muck in together we can all get the jobs done more quickly and that gives us more time to do the pleasant bits and spend quality time with the people." We saw all care staff would spend time in communal areas talking with people either quietly on their own or with small groups.

We looked at the system in place for the safe storage and management of medicines. We saw that there were robust systems in place to minimise risk and were told that there had been no medication errors over the past year. Medicines were ordered monthly; two weeks in advance to allow time for delivery and appropriate checks to be made and delivered on by the pharmacy using a monitored dosage system and including pre-measured dosages of liquid medicine in pots. This minimises the risk of giving the wrong dose to people and provides an efficient system of storing and accounting for medicines. Prescriptions were checked against delivery, signed for and countersigned to ensure that the appropriate medicines were delivered. Unused medicines and tablets were noted and stored in a returns box for returning to the pharmacy.

A locked medicines room was used to store the medication trolley and all other medicines for the service. Refrigerator temperatures were checked daily and a record of temperatures was kept, in order to ensure medicines are stored at the correct temperature. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. Controlled Drugs were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. We checked the balance of controlled drugs for two people and found them to be correct.

Each person requiring medicines had a Medication Administration Record (MAR). This is a form which records the details of any medicines prescribed, when they are taken, and if they are refused. All medicines received were recorded on the MAR which also included details of the medication, a diagram of the tablet, and dose required; a recent photograph of the person and details of GP, condition, and any known allergies. Medicines were administered by senior care staff who had received specific training on handling medicines. We spoke with one senior carer who informed us that they had completed regular medication training and confirmed that they were happy with the training received.

We saw that one person received their medicine covertly. Medication given covertly is the administration of any medical treatment to a person in a disguised form, such as sprinkled over food. We saw that this had been agreed following best interest discussions and authorised as in the person's best interests by the general practitioner (GP) with advice on administration clearly recorded.

Staff had undertaken infection prevention and control training, and those we spoke with understood the

importance of infection control measures, such as the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care. Anti-bacterial hand gel dispensers were situated throughout the home. Posters detailing correct hand washing procedure were on display in all toilets and bathrooms and in the kitchen and laundry.

We inspected the kitchen and saw that it was clean and that the daily cleaning schedules were completed correctly. Food was stored safely and the fridge and freezer temperatures were monitored and recorded daily. These procedures helped to minimize the risk of food contamination. A 'Food Standards Agency' inspection had been carried and the home had been awarded the highest rating.

Good

Is the service effective?

Our findings

When we spoke with people who used the service and their visitors, they told us that they felt the staff were competent and knowledgeable. One person who used the service told us, "The staff are very clever, they know so much about how to help all of us." Staff themselves were complimentary about the training they received. One told us, "We get the right level of training to do our job and more. We do a lot of e-learning and we are all very competitive, and try to get ahead of each other."

We saw from records that when staff first started at the home they received a full induction and were subjected to a probationary interview after six months.

Discussions with the registered manager, observations and conversations with staff showed they had an in depth knowledge and understanding of the needs of the people they were looking after. We saw that staff had completed the essential training required, including the Skills for Care Common Induction Standards, which ensures staff have the right skills and level of competence to provide care and support to people who might need it.

The service set clear expectations for the staff and provided on-going training to ensure that staff had the skills to carry out their role. From the training matrix (record), which maps out the training staff have completed, we saw that care staff had completed courses in such areas as safeguarding adults, first aid, medication, food hygiene, dementia awareness and conflict resolution. Additional training in medication and safe administration of medicine was provided for senior care workers. One care worker we spoke with informed us that they had attended training for end of life Care, which followed the six step principles of care for the dying. They told us that they had benefited from this course in ways they had not expected: It's not just about end of life, it's about care. It helps you to be a better carer, how to work with people and their families." They explained that the training had been beneficial and how they had passed on their newly found knowledge to colleagues to help improve service delivery.

The registered manager kept a timetable which showed that all staff received a supervision session every two months and a yearly appraisal. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. We looked at two staff supervision records which showed that meetings were productive and staff used the opportunity to discuss issues of concern. The service also used a 'dignity audit tool' where staff were asked to rate themselves on a number of issues, which could then be analysed during supervision to aid progress. Questions related to dignity challenges, such as respect, privacy, autonomy, and self-esteem.

We saw that staff communicated well with each other and passed on information in a timely fashion. All staff attended a changeover meeting at the start and finish of each shift. This helped to ensure that staff are given an update on a person's condition and behaviour and ensure that any change in their condition had been properly communicated and understood. Staff shared information about individual people who used the service and tasks were delegated. Additionally the shift leaders would conduct a 'mobile changeover' where they will walk through the home. This gave the incoming shift leader a chance to observe all parts of the

home and visually note any actions needed, and talk through any issues arising from the previous shift.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us and we saw information to show that six applications to deprive people of their liberty had been authorised by the supervisory body (local authority), and we had been notified of these authorisations. A further nine were awaiting authorisation, and one awaiting reassessment. Capacity assessments had been completed to determine why people needed a DoLS authorisation. This helped to make sure that people who were not able to make decisions for themselves were protected.

The care staff we spoke with were able to demonstrate a good understanding of capacity and consent issues to help ensure that people's rights were protected, including pathways to reach best interest decisions. One member of staff gave us an example where the rights of the individual to refuse a specific type of medicine had been considered and balanced alongside their duty of care, and the need to maintain the person's independence.

Inspection of four care records showed there was an eating and drinking care plan and that people were weighed regularly. We saw that attention was paid to people's food and drink and people received a nutritionally balanced diet. The kitchen displayed information about specific dietary needs and staff understood the specific requirements of people living at Dryclough Manor. People told us that they enjoyed the food on offer. One person who used the service said, "The food is always good, we get fresh food and then they bring fruit and biscuits. They make sure we have plenty to drink too."

There were two hot meals served each day, with the main meal at lunchtime. Tables were set with plain tablecloths, paper napkins, cutlery, plastic wine glasses, and salt and pepper. The menu was clearly displayed in the dining area, and the cook told us that the menu was planned in advance. Shortly before the meal was due to be served, we saw she would ask each person which of two choices they would prefer. On the day of our inspection, most people had chosen Cornish pasty with chips and vegetables. The food was well presented and smelled appetising. People who needed help to eat were assisted appropriately.

People had good access to healthcare and staff monitored their physical and mental health needs. Weights were regularly checked, and the service had established good working relationships with speech and language therapists to monitor diet and swallowing, and physiotherapists for advice around mobility. Evidence in the case notes we reviewed showed liaison with district nurses, regular health checks and GP visits for example, to monitor skin integrity. We saw in care plans that people had regular access to other treatment such as dentist, optician and chiropody appointments. This meant that people were receiving care and support to access additional health care services to meet their specific health needs.

Good

Is the service caring?

Our findings

People told us they found that care staff knew them well and were kind and caring. One person told us, "I like it here, it is excellent. We can relax, the staff always look after us and check we are OK, or they will leave us alone if we need peace and quiet, they respect that. They do the hard work." A visiting relative remarked, "I really do feel that they [the staff] genuinely care, and they do a really good job." This person told us that they were impressed by the way staff spoke to people who used the service, and throughout our visit we saw that staff treated people with dignity and respect. One member of care staff told us, "They are all different characters but we respect them all. I think to myself 'that could be me in some years' time,' so I try to respond the way I would want to be treated."

When we arrived at the care home a number of people were already up and dressed, and eating breakfast. All appeared washed and well dressed. There were no set rising times, and people were being assisted to get up in their own time. We saw that as staff were assisting people to get up they would knock on their door and introduce themselves by name before entering and ask if the person was ready to get up. They continued to treat people in a caring manner throughout the day, and respond appropriately to their needs.

We saw that people were addressed by their preferred names and spoken to in a friendly manner making eye contact and touch where appropriate. Interactions between care staff and people who used the service were respectful and caring. On the day of our inspection a visiting hairdresser was visiting the service and as people had their hair done, staff were complimentary and remarked on how well they looked.

Throughout our visit we observed positive and meaningful interactions between staff and people who used the service. Care staff were polite and respectful, and displayed a good understanding of the individuals' personality. They would respond in an appropriate manner, for example, sharing a self-deprecatory joke with people, or discussing activities that the person was interested in.

The care workers we spoke with demonstrated a good knowledge of the people who used the service, their lives likes and past histories. We saw care staff spending time with people who used the service, for example sitting and talking with them and encouraging a steady conversation. At the same time they remained vigilant, for example we observed a member of staff who was talking quietly in a lounge with a person who used the service. They noticed another person was beginning to get agitated and excused themselves from their conversation, and attended to the need of the second person. Once this person was settled they returned to finish off their original discussion.

People were encouraged to form friendships, and we saw evidence that people had developed new friendship groups since they moved in to Dryclough Manor. Staff also supported people to maintain relationships with family and friends. Feedback from visitors was positive about the care provided, and the relatives we spoke with had no issues about the quality of care. There were no restrictions on visiting and those visitors we spoke with told us that they were always welcomed and supported when they visit. They informed us, and we saw that staff knew them and greeted them by name. A relative told us that the staff were always available, friendly and knowledgeable.

We observed that people were asked discreetly about their personal care. When people needed assistance with personal care we observed that staff ensured they closed doors in bedrooms and bathrooms. All the people in the home were clean and well presented. Care was taken to support people with personal needs. People told us that the staff take time to ensure they were well groomed and that they thought the care staff made an effort to get to know them. Staff agreed that this was important and spoke affectionately about the people they supported.

People's privacy and confidentiality was maintained. All bedroom doors had locks and if people wanted they could have a key to their room. The registered manager informed us that only one person locked their room when they were not using it. Staff were aware of the need for confidentiality and we saw they were discreet when talking to professionals on the telephone. Care records were stored electronically with password protection so information held about individuals was secure.

The home had an equality and diversity policy, and the staff we spoke with had a good understanding of what this meant and gave examples of how they would respect people's individual beliefs, culture and background.

Staff had a good understanding of the needs of people approaching the end of life. We saw evidence in the care files we looked at that personal wishes had been considered, and individual plans made for this aspect of care, including DNAR records. A DNAR (do not attempt resuscitation) form is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation (CPR). We asked staff how they supported people who were nearing the end of their life and they were able to explain how they would consider their needs, and liaise closely with families and relevant health staff to deliver high quality end of life care in a compassionate and understanding manner.

Good

Is the service responsive?

Our findings

People who used the service told us that staff responded positively to their needs, respected their autonomy and promoted their independence, providing them with support when they required it. One person told us "Yes, the staff look after us. They help with dressing and showering. I do as much for myself as I can but they are there for us when we need the help. If I ring they are there straight away."

We looked at four care records. These were computerised, and provided up to date records for each person who used the service. Information about each person titled 'About Me' was detailed and written in a person centred way focussing on his or her abilities and strengths. Information provided gave a good indication of the person's character, personality, background and history prior to admission at Dryclough Manor, as well as recording checks on 'vitals' such as weight, body mass, MUST Score (Malnutrition Universal Screening tool: this identifies if a person is at risk of malnutrition or obesity) and Waterlow score (reflects the risk of developing pressure sores).

The care records contained detailed information to guide staff on how to provide care and support and could be cross-referenced to daily activities charts where staff would record details of the activity provided. They also showed that risks to people's health and well-being had been identified, such as the risk of poor nutrition and the risk of injury. Where a risk had been noted action to reduce or eliminate any identified risk was recorded in detail. We saw that specific specialist information and guidance from the relevant professionals involved in their care was contained within the care records. The records were reviewed regularly to ensure the information was fully reflective of the person's current support needs.

People told us that they were asked how they would like their care to be delivered, and we saw that those who were able to participate in their care reviews were welcomed. Reviews of care recorded who had been consulted in the review. When we spoke with relatives of people living at Dryclough Manor they told us that they were kept informed of people's needs and their views were solicited. One visiting relative told us that they were regularly kept informed of any changes in care needs of their relative and had been fully consulted on decisions regarding capacity and consent. They told us that the service would contact them immediately if there were any issues regarding their relative. They also told us that they were regularly asked for their views on service delivery, and were invited to relatives meetings. We saw that these meetings were held four times each year.

The service employed an activity coordinator, who organised regular daily activities for the people who used the service. On the day of our inspection, there was a bingo session in the afternoon, which a number of the people who used the service participated in, and they appeared to enjoy the session. This was followed by an impromptu singalong, equally enjoyed by participants. Other organised activities included a regular 'keep fit' session and visits from local entertainers.
In addition to organised activities, we saw that care staff were attentive to the social needs of people who used the service and would ensure that people were not isolated. A visiting relative told us that they believed the outgoing nature of the care staff stimulated people who used the service and stopped them from becoming bored. We saw that people were not left in isolation and staff would take time to sit and talk with

people who used the service, stimulating conversation and inviting others to join in. When we asked one person about their daily routine, they told us "Activities aren't for everyone. I'm happy to go for a walk in the garden, or stay and watch the world go by. Yes, I've made quite a few friends since I came here, and relatives can visit often, they can come whenever they like."

We saw the service had a complaints policy, and the complaints procedure was on display in the lobby of the home where it was easily accessible. We saw that the registered manager kept a computerised log of any complaints made, investigations undertaken, and the action taken to remedy the issues. We noticed that a recent substantiated complaint regarding a carpet was not yet resolved. When we spoke with the registered manager she informed us that the owners had agreed to replace the carpet, but was waiting until a proposed extension had been completed.At the time of our inspection planning permission for this extension had been granted, and the provider was seeking tenders to complete this work. Once done, the area would be fully redecorated and carpeted.

Good

Is the service well-led?

Our findings

We saw that Dryclough Manor had a highly developed sense of belonging amongst the staff and the people who used the service. One person who used the service said to us, "this is our home. We have good days and bad but we look out for each other." The registered manager told us, "Everyone here is close, there is a family feeling and people want to be in work. Nothing is too much trouble for the staff."

The positive culture of the service was reflected in the interactions we observed to encourage individuals and listen to them as well as providing support. A visiting relative, reflecting on the culture of the service, observed that the staff would "jolly people along", and had the skills to gently coax individuals to participate in their care. They told us that people were held in positive regard, and carers were allowed to express warmth and encouragement, whilst remaining professional in their work, ensuring that routine tasks were not overlooked. We saw staff were highly motivated and worked together as a team; sickness levels were low and a large number of the staff had worked at Dryclough Manor for ten years or more. Whilst this can lead to complacency, systems of supervision, peer support and annual appraisal ensure that staff remained diligent and focussed on the needs of the people who used the service.
The people who lived at Dryclough Manor were supported by trained staff who understood the needs and wishes of people who used the service.

The relatives of people living at Dryclough Manor who we spoke with told us that they were kept informed of any changes in their relative's condition and felt comfortable about contacting the service. We saw minutes to show that they attended relatives meetings and were kept informed of any changes to the service or any new developments. This also gave them an opportunity to air any collective concerns about Dryclough Manor.

The service encouraged feedback from all stakeholders, and conducted a six monthly survey for staff, people who used the service and relatives. The results were displayed in the home, and showed a high level of satisfaction for each group. For example, when asked, "Do you find the staff approachable and are you able to ask them questions?" 90% of respondents replied 'very helpful, and 10% helpful. In response to "are you treated with dignity?" and "Is your privacy respected?" all the people who used the service answered positively.

Dryclough Manor had a registered manager who had been registered for five years, and was present throughout the inspection. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Everyone we spoke with held the registered manager in high regard. One member of staff said, "She's great. Approachable, a good listener, and a hands-on person. She is willing to muck in and will always help." The manager was equally complimentary about the care staff, and remarked on their dedication and willingness to work as a team. Care staff told us, and we saw, the registered manager was visible around the home every

day when they were on duty.

Staff were aware of their roles and responsibilities. Staff meetings were held as and when required and we saw that the last meeting in July was well attended, and those staff unable to attend had signed the minutes to say that they had read them. At shift changeover, tasks would be delegated so individuals would know what was expected of them for each shift, and a 'shift leader' was appointed to take overall responsibility under the leadership of the registered manager or assistant manager. The service operated a key worker system, and when we spoke with a member of staff about this, they were able to tell us clearly what the role entailed, but added, "It only works if we are a team. We all have to muck in."

Staff communicated effectively across all departments of the service, for example, the kitchen staff were made aware of any changes to dietary requirements by the key worker immediately. In addition, the home held three monthly governance meetings with all heads of department.

We asked the registered manager to tell us what systems were in place to monitor the quality of the service to ensure people received safe and effective care. We were told that regular checks were undertaken on all aspects of the running of the service, for example, the registered manager would undertake a monthly quality check of the lounge areas and bedrooms and report findings to the provider. She told us the provider was supportive, and would meet any reasonable requests for additional resources. For example, and were in the process of replacing bedroom furniture to make rooms more homely.

The registered manager was able to show us a record of quality audits completed on a monthly or yearly basis, including medication, nutrition, mental health, care plans and dementia care. We looked at a detailed audit of accidents and incidents, which allowed for analysis of any trends or issues arising due to either environmental issues or changes in the individuals. We saw that this had highlighted an issue regarding a person's mobility, and allowed proactive intervention to reduce the risk of further occurrences.

We looked at a recent audit of maintenance records, which showed that all maintenance checks (e.g. legionella, gas and electric checks, lift maintenance etc.) had been completed, and were up to date.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.