Croftwood Care UK Limited

Ancliffe Residential Care Home

Inspection report

Warrington Road
Goose Green
Wigan
Lancashire
WN3 6QA

Website: www.minstercaregroup.co.uk

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10 July 2018
11 July 2018

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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

We carried out an inspection of Ancliffe Residential Care Home on the 10 and 11 July 2018, the first day of inspection was unannounced. This was the first time the home had been inspected since it re-registered with the Care Quality Commission in November 2017, due to a change in ownership.

Ancliffe Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The home is located in Goose Green, a residential area approximately one mile from Wigan town centre and is registered to provide accommodation for up to 40 people who require personal care and support. At the time of this inspection 40 people were living at the home, although three were in hospital.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Each person we spoke with told us they felt safe and enjoyed living at Ancliffe Residential Care Home. Relatives were also complimentary about the standard of care provided. We saw staff had received training in safeguarding, which was refreshed in line with the providers policy and knew how to report concerns. The home had appropriate safeguarding policies and reporting procedures in place and had submitted notifications to the local authority and CQC as required.

We found the home to be clean with detailed cleaning checklists and appropriate infection control processes in place. Staff wore personal protective equipment (PPE) to prevent the spread of infection and toilets and bathrooms contained hand hygiene equipment and guidance.

People, relatives and staff told us enough staff were on duty to safely meet needs. Staffing levels were based on people's dependency levels and rotas we viewed during the inspection confirmed the required number of staff had been deployed at all times, with any shortages due to sickness or absence filled by existing staff members, to ensure consistency of care.

We saw medicines were stored, handled and administered safely and effectively. All necessary documentation was in place and had been completed consistently. The home's quality monitoring procedures, had highlighted any gaps or omissions in medicines documentation and taken steps to address this. Staff responsible for administering medicines had been trained and had their competency assessed.

We found care files contained detailed risk assessments, which had been regularly reviewed to reflect people's changing needs. This ensured staff had the necessary information to help minimise risks to people living at the home.

Staff spoke positively about the support and training provided. We saw staff had completed an induction programme upon commencing employment and on-going training was provided, both e-learning and practical, to ensure skills and knowledge remained up to date. Staff also told us they received regular supervision and annual appraisals, which along with the completion of quarterly team meetings, meant they were supported in their roles.

We found meal times to be a positive experience, with people being supported to eat where they chose. Staff engaged in conversation with people and encouraged them throughout the meal, providing support to those that required it as per their care plan. Food and fluid charts had been used where people had specific nutritional or hydration needs, with clear guidance in place for staff to follow.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be caring and treated people with kindness, dignity and respect. It was apparent from our observations, staff knew the people they supported and had formed positive relationships. People told us they would feel comfortable raising any issues of concern with staff members.

All staff members we spoke with demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We saw the service was working within the principles of the MCA and had followed the correct procedures when making DoLS applications.

People living at the home were encouraged to make decisions and choices about their care and had their choices respected, whilst being supported in the least restrictive way possible; policies and systems in the home supported this practice. People's consent to care and treatment was also sought prior to care being delivered.

We looked at five care files, all of which contained personalised information about the people who used the service and how they wished to be supported and cared for. Each file contained concise, yet informative care plans and risk assessments, which helped ensure people's needs were being met and their safety maintained. People and their relatives told us they were involved in care planning and reviews.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be caring and treated people with kindness, dignity and respect. It was apparent from our observations, staff knew the people they supported and had formed positive relationships. People told us they would feel comfortable raising any issues of concern with staff members.

Peoples' social and recreational needs were met through the provision of an activities programme. Alongside in-house activities, we saw the home arranged visiting entertainers and speakers as well as group outings to places people had shown an interest in attending or had been discussed during resident meetings.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily, weekly, monthly or quarterly basis, depending on the area being assessed and covered a wide range of areas including medication, accidents and incidents, infection control and training. Provider level audits had also been completed on a monthly basis, to provide further oversight of all aspects of service provision.

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 we spoke with told us they felt safe living at Ancliffe. Staff were trained in safeguarding procedures and knew how to report concerns.

Staffing levels were appropriate to meet people's needs.

Medicines were stored, handled and administered safely by trained staff that had their competency assessed regularly.

Is the service effective?

Good

The service was effective.

All staff spoken to had knowledge of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS) and the application of these was evidenced through care files and the matrix.

Staff reported sufficient and regular training and supervision was provided to enable them to carry out their roles successfully.

The dining experience was positive and we saw nutritional needs were being assessed and provided as per prescription.

Is the service caring?

Good

The service was caring.

People living at the home were positive about the care and support provided, telling us that staff were kind, respectful and treated them with dignity.

Staff had a good understanding of the people they cared for and were mindful of the importance of promoting people's independence.

People's preferences were captured within care files and care was provided in line with their wishes.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person-centred way.

The home had an activities programme in place. People we spoke with were positive about the activities and outings available.

The home had an effective complaints procedure in place, with all complaints whether written or verbal being investigated and outcomes documented.

Is the service well-led?

Good

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, with action points generated and details of progress clearly documented.

Both the people living at the home and staff working there said the home was well-led and managed and that they felt supported by the registered manager.

Meetings were held regularly to ensure that both people and staff had input into the running of the home and were made aware of all necessary information.

Ancliffe Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 10 and 11 July 2018. The first day of the inspection was unannounced.

The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC).

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also spoke to the quality assurance team at Wigan Council.

Before the inspection, the provider completed 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 improvements they plan to make.

During the course of the inspection we spoke with the registered manager, area manager and three staff members. We also spoke with seven people who lived at the home, one relative and a visiting professional.

We looked around the home and viewed a variety of documentation and records. This included; five staff files, five care files, nine Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

Good

Is the service safe?

Our findings

We asked people living at the home if they felt safe. Each person we spoke with confirmed they did, comments included, "Oh very, no fears at all, the girls check up on me during the day and at night," and "Yes, I do, there's someone around all the time to look after us." A relative told us, "Is my mum safe here, oh definitely, they are very good."

We looked at the home's safeguarding systems and procedures. We found staff had all received training in safeguarding adults, which was regularly refreshed to ensure knowledge remained up to date. The home had a safeguarding file in place, which contained a copy of the local authority reporting guidance, along with a log to record all referrals and outcomes. We found this had been completed fully and accurately and showed concerns had been managed appropriately.

We looked at five staff personnel files to check if safe recruitment procedures were in place. We found robust checks were completed before new staff commenced working at the home. The files included; an application form, proof of identity and at least two references, along with Disclosure and Barring Service (DBS) check information. A DBS is undertaken to determine that staff are of suitable character to work with vulnerable people. Existing staff had also signed an annual declaration, to confirm they had not received any cautions or convictions within the last 12 months, as these could affect their employment.

People we spoke with provided mixed feedback when asked if there was enough staff on duty to support them. Comments included, "I don't think so, the staff are so busy they don't have much time to sit and chat with me," and "No, the poor girls are rushed of their feet, I think they could do with more." Whereas others stated, "Yes, there's always someone available when I need anything," and "Yes there are, they come quickly if needed and always someone around."

Staff confirmed they were very busy, but felt they could safely meet people's needs. One stated, "We do our best, workload has got harder as people we support are getting more complex, but we manage to meet people's needs."

We saw the home used a system for working out the number of staff needed per shift to meet people's needs; these are sometimes called a 'dependency tool'. We looked at four weeks rotas and found the number of staff deployed matched the amount indicated on the tool. Any shortfalls had been covered by existing staff members working additional hours.

We found accidents and incidents had been clearly documented and managed appropriately. Post-accident or falls observations had been carried out for up to 72 hours, to ensure the person was safe and well. Where people had experienced a fall or accident, we saw risk assessments had been re-visited and care plans updated. Weekly falls monitoring had also been completed, to look for trends and minimise the risks of reoccurrence.

As part of the inspection we checked the systems in place to ensure safe infection control practices were

maintained. Bathrooms and toilets contained hand washing guidance, along with liquid soap and paper towels. Staff had access to and used personal protective equipment (PPE) such as gloves and aprons, to minimise the spread of infection. Each area of the home was clean and free from odours.

The home had effective systems in place to ensure the premises and equipment were safe and fit for purpose. Safety certificates were in place and up to date for both gas and electricity, hoists, the lift and fire equipment, which had all been serviced as per guidance with records evidencing this. Call points, emergency lighting, fire doors and fire extinguishers were all checked regularly to ensure they were in working order. There was an up to date fire risk assessment in place, along with personal emergency evacuation plans (PEEPs). The introduction of the Regulatory Reform (Fire Safety) Order 2005 places the onus on providers to ensure that everyone can evacuate safely in the event of a fire or emergency evacuation. In order to comply with legislation, a personal emergency evacuation plan (PEEP) needs to be devised by a responsible person. The PEEP will detail the escape routes, and identify the people who will assist in carrying out the evacuation.

We looked at the home's management of medicines, which included reviewing documentation, checking stock levels and ensuring staff had the necessary guidance to ensure they administered medicines safely and when people needed them. We saw staff had received training in medicines management and had their competency assessed annually.

We looked at medicine administration records (MAR's) for nine people and found these had been completed accurately and consistently. Stock checks of these person's medicines showed the amount remaining tallied with the amount received and what had been administered, which confirmed people had received their medicines each day as necessary.

Each person had a medication care plan which included a list of all medicines prescribed and how they wanted to take these. The care plan also covered whether people required their medicines to be given covertly, which means without their knowledge. Where this had been deemed necessary, we noted a 'covert medicines pathway' document had been used, to ensure all the necessary steps had been taken prior to this commencing. This included the completion of a meeting to ensure doing so was in the person's best interest and to gain authorisation to administer medicines covertly from the GP and guidance from a pharmacist on how this should be done.

We saw 'as required' (PRN) protocols in place for people who took this type of medicine, such as paracetamol. These provided staff with information about how much to give, when to administer and what signs to look for it may be required, in case the person couldn't tell them. This ensured medicines had been administered safely and when needed.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines had been administered and documented as per guidance.

Good

Is the service effective?

Our findings

People living at the home told us they enjoyed the food and got enough to eat and drink. One person told us, "It's not bad, the chef is good and if you don't like something they will make you something different." Another said, "The food here is nice and we get plenty of it." A relative we spoke with told us, "Mum enjoys the food, they have managed to get her to eat and she's even put some weight on which is good."

We saw a fridge was located in reception which contained bottled water that was free for people living at the home. During the course of the inspection we observed fluids being offered throughout the day, including tea, coffee and juice. People told us they could request a drink at any time and had no concerns about remaining hydrated, which was particularly important at this time, due to the recent hot weather. Hydration guidance was clearly displayed within the home, which covered the amount people needed to consume and how much liquid each different cup or glass contained, to assist staff to work out how much people had drunk.

We observed a positive meal time experience on both days of the inspection. Dining tables were set up prior to meals being served, with each one containing a table cloth, napkins, cutlery and a vase of flowers. The menu was clearly displayed and people were asked what they wanted to eat. We noted visual aids were available, which included pictures of meals along with their name, to assist people in making choices. People who required support to eat received this in a discreet and respectful way. We noted people who required a modified diet, such as mashed or pureed meals, received these in line with their care plan.

We looked at how the home managed people's nutrition and hydration needs. Care files contained a Malnutrition Universal Screening Tool (MUST); which is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. We saw these had been completed and updated timely to reflect people's changing needs. Nutritional plans were detailed and contained sufficient information to guide staff on each person's individual requirements, including what they liked to eat and any aids and adaptations required, such as special cutlery or beakers. Food diaries had been implemented when required, such as if a person had experienced weight loss or the use of one had been recommended by professionals.

We saw people's weights had been closely monitored. People had been weighed either weekly or monthly, depending on their needs and referrals made to relevant professionals, such a dieticians, if weight loss had been detected.

We looked to see how the service managed people's pressure care. We saw the home championed the React to Red pressure ulcer prevention campaign, which aims to educate as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them. We saw pressure risk assessment tools had been consistently completed and body maps used to detail people's skin breakdown. When people had been identified as at risk, we saw they had the necessary equipment in place, for example; air flow mattresses and pressure relieving cushions. Positional change records were in place, with codes used to indication the person's position before and after turning. These had been completed consistently

and at the frequency contained in the care plan. We saw referrals to professionals, such as tissue viability nurses (TVN's) had been made where appropriate.

We saw the service worked closely with other professionals and agencies to meet people's health needs. Involvement with these services was recorded in people's files and included general practitioners (GP's), chiropodists, district nurses, advanced nurse practitioners (ANP's) and speech and language therapists (SaLT). People spoke positively about the support they received in this area, one person told us, "Every time I have had an appointment a carer has come with me."

The people who lived at the home and their relatives told us staff had the right knowledge and skills to provide effective care. Comments included, "Oh yes, you can't fault them, all know what they are doing," and "Yes, very well trained. They go above and beyond the call of duty."

We looked at the homes staff training documentation which was stored electronically. The training matrix showed staff had received training in a number of areas relevant to their role, including, safeguarding, moving and handling, infection control, health and safety and first aid. The matrix was colour coded to indicate training that was in date, due to expire or had expired. We saw evidence that staff had been enrolled on refresher courses for any training that had or was due to expire. We also saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015.

The staff we spoke with said they received regular supervision and an annual appraisal. Completion of supervision meetings was monitored both electronically and via a wall mounted board in the manager's office, to ensure these occurred as per company policy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People 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 MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both.

The home used a log to monitor DoLS applications. At the time of inspection ten applications had been submitted, although only three assessments had taken place. We saw evidence the home had chased the outstanding assessments. Within people's care files we saw that any potential restrictions had been dealt with as per the MCA, with best interest meetings held and the least restrictive intervention being utilised.

We looked at how the home sought consent from people. People who had the capacity to do so, had signed a consent form, agreeing to the care and support provided, their photograph being used for identification purposes and for others to have access to their records as required. Where people lacked capacity, decisions had been made via best interest meetings. During the course of the inspection we observed staff knocking on people's doors and waiting for a response before entering, staff asked people if they wished to take their

medication and would they like to participate in the activities on offer. One person told us, "The staff always knock on my door and ask me if I need any help."

We saw some consideration had been given to ensuring the environment was 'dementia friendly'. Corridors were light and airy with plain flooring and walls, which had contrasting coloured handrails to make them easier to identify. Large pictorial signage was in place on all bathrooms and toilets and there was also a large pictorial board which informed people of the day, date time and weather.

Good

Is the service caring?

Our findings

The people we spoke with were complimentary about the care and support they received. Comments included, "The girls are wonderful workers, very kind and caring," "They are all very caring, I consider them friends," and "I am well looked after, I'm very happy with the care I am getting." A relative told us, "From what I see, the staff are very kind to people here, they seem to know them all really well and treat everyone with respect."

People told us they were treated with dignity, respect and were given privacy at the times they needed it. Staff were mindful of the importance of preserving people's dignity and were able to describe ways in which this was achieved. One told us, "Give people a choice, ensure their privacy is maintained by being discreet and covering up when providing personal care." Another added, "I make sure doors and curtains are closed and I explain what I am going to do, to make sure they are happy with this."

Throughout the inspection we observed a positive atmosphere within the home. People were animated and engaged in conversation within the various communal areas. People looked clean and had made an effort with their appearance. A relative told us staff were mindful of the importance of promoting this, stating, "My mum is cared for how she would like to be, the staff make sure she is always clean and well groomed, which is important to her."

We observed care delivery throughout the course of the inspection and saw staff were courteous and kind at all times. Staff took time to explain what they were doing and confirmed with people they were happy to be assisted before undertaking care tasks. We observed occasions when people needed to be supported to the toilet, these instances were managed sensitively and discreetly. We saw staff interaction with people was warm, friendly and respectful. We observed appropriate physical contact between staff and people; for example, hugging, rubbing people's arms and holding hands. Each of these interactions was received warmly by the person involved.

People we spoke with confirmed staff knew what they wanted and offered them choice. They felt this was due to the home having a good staff retention rate, which meant staff had learned to know their preferences and how they wanted to be cared for. One said, "The girls know exactly what I need. They do all sorts for me, like going to the shop as they know I can't get out."

The staff we spoke with displayed an awareness and understanding of how to promote people's independence. One said, "It's about assisting them, encouraging them, getting them motivated. We prompt people to wash themselves, choose their own clothes and get dressed, just helping where they need it." People we spoke with conformed this was the case, one stated, "Yes, the staff let me do things for myself. I am encouraged to walk short distances with my Zimmer frame, to keep mobile." Another said, "Yes, they do though they keep an eye on me, to make sure I'm not doing too much; if I am they will tell me to take it easy."

There was a positive culture at the service and people were provided with care that was sensitive to their

needs and non-discriminatory. Staff were mindful of the importance of catering for people's diverse needs, whether these be spiritual or cultural. Care files contained sections which captured people's needs, wishes, religious and cultural beliefs or requests. At the time of inspection nobody living at the home had any specific requirements, however staff told us these would be catered for. We were also informed people were supported to receive communion, with one staff stating, "Both a catholic and protestant priest come into the home, to provide communion to people who wish to take this."

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the service had met this standard. We saw people had communication care plans which explained how they communicated with others, including the use of body language and facial expressions for those with limited verbal communication skills. The care plans also covered difficulties the person experienced along with equipment's they relied upon, such as glasses, hearing aids or picture cards.

In one care file we viewed we noted the local sensory team had been involved and provided the person with aids and specialised equipment to support them at meal times, due to them having a visual impairment.

Good

Is the service responsive?

Our findings

People we spoke with and their relatives told us they had been involved in the care planning process, including making choices about their care and how they wanted to be supported. Comments included, "I decided what I wanted," "Oh yes, I'm involved in my care, they are great at this," and "Yes, I was involved. Many times since, staff have asked if I am okay and happy with things." A relative stated, "They held a place for mum, completed an emergency assessment, went above and beyond in my opinion. The care plan was discussed with me at the very start."

We saw the service provided care which was personalised and responsive to people's individual needs and preferences. Pre-admission assessments had been completed for all people living at the home. These captured key information about the person including past and present medical information, areas of need and support required, which ensured staff had an understanding of the person's needs prior to moving in and assisted with the initial writing of the care plan.

During the course of the inspection we reviewed five care files. Each person's file contained a 'life plan', which stated at the beginning, 'My life plan will help you know who I am and what we can do together to help me enjoy a satisfying lifestyle'. We saw a range of personalised information had been captured including people's life history, educational and work background, any memorable places along with hobbies and interests. This ensured staff knew what was important to each person and helped inform the care planning process.

Care files contained a range of personalised care plans which covered areas such as personal care, nutrition, mobility, communication, mental health and wellbeing. Each care plan detailed what the person liked or was able to do, and what help they required from staff, including how best to promote and increase independence. Each care plan was concise yet covered all required information and provided staff with clear guidance on how each person wished to be supported. We saw reviews of care plans had been completed on a monthly basis and updates made timely, when any changes had occurred.

During the inspection we noted other examples of person centred practice, for instance one person had individualised meals made for them, due to their chosen dietary preference. The home had also gone to great lengths to maintain the support of a person with behaviours that challenged, making referrals to Later Life and Memory Service (LLAMS) for additional support, as well as implementing one to one care.

None of the people we spoke with or their relatives had made any complaints about their care, but told us if they had a problem they would speak to a member of staff. Comments included, "I would go to the office if had an issue," and "I could either write it down or go to [registered manager]. I wouldn't hesitate but not needed to do it."

We looked at how complaints were handled. The notice board contained a copy of the complaints procedure, which was accessible to all people living at the home. The home had a complaints and concerns file in place, which included the policy and procedure for dealing with any concerns. The file included a

monitoring log which also summarised any complaints or concerns received. We saw only five minor concerns had been reported since November 2017, for example someone's room being too hot as their radiator was faulty or the noise caused by delivery vehicles visiting the home in the morning. Each concern had been addressed with actions taken recorded.
The home displayed thank you cards and notes on noticeboards within the home, as well as keeping comments on file. Examples of recent communication received from people who had used the service or their relatives included, 'Thank you all so much for the care you gave to [name]. The time invested into caring for [name] warmed my heart.' 'For the wonderful care you gave to [name], I can't thank you enough,' and 'Mum is very happy at Ancliffe. All the staff are lovely with her. [Name] makes mum laugh and lifts her spirits when she's a bit low.'

We looked to see how people spent their day and what activities were carried out at the home.
All but one of the people we spoke with felt there was currently enough going on. One person said, "Yes, there's enough, the lady in charge of activities does a lot. We do bingo, exercise classes, they've taken some people on a barge trip, they have also taken me into town which I enjoyed."

The home employed a co-ordinator, who was responsible for organising and facilitating activities within the home. We saw each person had an activity profile, which included their interests and types of activities they would like to try. An activities book had been used to record people's participation in the daily activities provided, which was later transferred to people's individual activity records. This ensured there was a up to date account of people's activity engagement. The home also took photographs of any activities, events and outings, which were on display within the home to act as a reminder for people.

At the time of inspection, no-one living at the home was receiving end of life care. The home had documentation in place to capture people's wishes when nearing the end of their life, should they be prepared to discuss this. This included where the person wished to be such as remain at the home, or be in hospital, along with instructions relating to funeral wishes and final resting places. We saw the home worked closely with GP's and district nurses, to ensure people who wanted to remain at the home when approaching the end of their life, could do so safely and respectfully.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

Staff told us they enjoyed working at the home and felt supported by the registered manager. One told us, "Yes, I do enjoy it here, though its hard work. [Registered manager] is very good." Another stated, "You can go to [registered manager] at any time and bring things up."

People living at the home and the relatives we spoke with, knew the manager and felt the home was well-led. One person told us, "I think it's well run. [Registered manger] is very approachable." Another stated, "I remember [registered manager] visiting me at my previous home, they are a lovely person." A relative told us, "It's a really good home, I would happily recommend it to others." During the course of the inspection, we spoke to a visiting professional, who spoke also highly of the home, how well it was run and stated they had recommended it to one of their relatives.

People and their relatives had involvement in how the home was run through completion of quarterly resident meetings. We saw minutes from the most recent meeting had been displayed on the notice board. From reviewing the last four meetings minutes, we noted agenda items included whether people were happy with the meals provided, the activity schedule, laundry service, home maintenance and cleanliness. Events and outings had also been discussed along with an opportunity for people to raise any other business. People we spoke with confirmed meetings were held and that they found them useful. The home also captured people's views through annual quality assurance questionnaires, which asked people for the opinions on the care provided and the home in general. We saw feedback had been provided based on people's responses, with a report produced and circulated.

We saw staff meetings had also been completed quarterly, which were advertised for the upcoming year, to ensure staff had prior notice to help promote attendance. Additional meetings had also been held for staff in specific roles, such as care team leaders and senior carers. Staff told us the meetings provided on opportunity for information to be shared and for them to discuss any issues they wanted to disclose. We saw the home also had a staff welfare champion, who had a counselling qualification. This person was the first port of call for any staff who required support or just wanted someone to talk to.

We found accidents, incidents and safeguarding had been appropriately reported as required. We saw the registered manager ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements and copies of all notifications submitted were kept on file.

The home's policies and procedures were stored electronically and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated at provider level; this meant that the most up to date copies were always available. We spoke with staff who were able to

demonstrate a good understanding of the policies which underpinned their job role such as safeguarding people, health and safety and infection control.

The home used a range of systems to assess the quality of the service. An annual audit schedule had been drawn up which detailed when each audit would be carried out, to ensure the correct timescales had been followed and all areas completed. The frequency of audits varied depending on the area being assessed, ranging from quarterly through to daily. We saw audits had been completed for areas such as mealtime experience, medication, infection control, life plans, training completion and meetings. Each audit included a detailed action plan, which specified what steps had been taken to address any identified issues or shortfalls.

Alongside the internal audits, service provision at the home was also assessed via monthly provider level assessments, completed by the area manager. We saw this involved an 'inspection' of the home by the area manager who looked at all areas of the service provided, observed care, reviewed documentation and provided a rating, based on CQC's ratings of inadequate, requires improvement, good or outstanding. We saw action plans had been generated, which were reviewed as part of the next month's visit, to ensure follow through and continuous improvement.