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Langdale Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was a comprehensive inspection that took place on 19 and 20 July 2016. The first day of the inspection was unannounced.

Langdale Residential Home provides both care and nursing for up to 31 people who are aged over 65 and who are living with Dementia or who have a physical disability. The home is located on two floors. Each person had their own bedroom. The home had a communal lounge, kitchen and dining room where people could spend time together. At the time of inspection there were 31 people using the service.

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.

People and staff felt the service was well managed. The service was led by a registered manager who understood most of their responsibilities under the Care Quality Commission (Registration) Regulations 2009. We found that not all statutory notifications had been submitted to the Care Quality Commission.

People were protected from the risk of harm at the service because staff had undertaken training to recognise and respond to safeguarding concerns. They had a good understanding about what safeguarding meant and how to report any concerns.

There were effective systems in place to manage risks associated with people's care and this helped staff to know how to support people safely. Where people displayed behaviour that may cause harm to themselves or others guidance was available to staff to help them to manage such situations in a consistent and positive way.

The building was well maintained and kept in a safe condition. Evacuation plans had been written for each person, to help support them safely in the event of an emergency.

People's medicines were handled safely and were given to them in accordance with their prescriptions. People's GPs and other healthcare professionals were contacted for advice whenever necessary. People had access to healthcare service when required.

There were enough staff to meet people's needs. People felt that they had to wait for support at times. Staff had been checked for their suitability before starting work to make sure people were supported by staff with the right skills and attributes. Staff received appropriate support through induction and supervision. There was an on-going training programme to provide and update staff on safe ways of working.

People were supported to maintain a balanced diet and guidance from health professionals in relation to

eating and drinking was followed. We saw that people were able to choose their meals.

People were supported to make their own decisions. Staff and managers had an understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). We found that DoLS applications and appropriate assessments of capacity had been made. Staff told us that they sought people's consent before delivering their support.

People or their representatives had contributed to the planning and review of their support.

People received support from staff who showed kindness and compassion. They told us that staff treated them with respect.

People received care and support that was responsive to their needs and preferences. Care plans provided detailed information about people so staff knew what people liked and what they enjoyed. People were encouraged to maintain and develop their independence. They took part in some activities that they enjoyed although people felt that the activities were limited. People were involved in developing their support plans.

Systems were in place which assessed and monitored the quality of the service. This included obtaining feedback from people who used the service and their relatives although people did not remember being asked for this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from risk of abuse and avoidable harm. Staff knew about their responsibilities for reporting any concerns that they had. Risks to people had been identified and assessed.

There were sufficient numbers of staff to meet people's needs safely. The service followed safe recruitment practices when employing new staff.

People's medicines were handled safely and given to them as prescribed. Staff were trained and deemed as competent to administer medicines.

Is the service effective?

Good

The service was effective.

Staff were trained to a standard that enabled them to meet people's needs. They received regular guidance.

People were encouraged to make decisions about their care and day to day lives. Consent to care and treatment was sought in line with the Mental Capacity Act (2005). Staff understood the requirements of this.

People received the support they required with their healthcare needs to keep healthy and well. People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect. Staff interacted with people in a caring, compassionate and kind manner.

People were supported to maintain their independence.

Staff knew people well and understood how each person wanted to be supported.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed in collaboration with them. Care plans provided information for staff about people's needs, their likes, dislikes and preferences.

There were activities that people participated in.

There was a complaints procedure in place. People felt confident to raise any concerns although were not aware of the procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager had not submitted all statutory notifications, as required by law to the care Quality Commission.

People knew who the registered manager was and felt that they were approachable.

People had been asked for their opinion on the quality of the service that they had received.

There was a range of audit systems in place to measure the quality and care delivered and so that improvements could be made.

Langdale Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 20 July 2016 and was unannounced. The inspection was carried out by two inspectors and a specialist nursing advisor.

Before our inspection, we reviewed the Provider Information return (PIR). The PIR is a form that asks the provider to give some key information about what the service does well and improvements they plan to make. We also reviewed information we held about the service and information we had received about the service from people who contacted us. We contacted the local authority that had funding responsibility for some of the people who used the service and the local Healthwatch. Healthwatch are an organisation who collects important information about people's views and experiences of care.

We reviewed a range of records about people's care and how the service was managed. This included five people's plans of care and associated documents including risk assessments. We looked at four staff files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people using the service and policies and procedures that the provider had in place. We observed how staff communicated with people who used the service and how they supported them throughout the day. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, the manager, the deputy manager, a senior care worker, two care workers, the activities manager, and the cook.

We spoke with four people who used the service and one relative who was visiting the service. This was to gather their views of the service being provided.

Good

Is the service safe?

Our findings

People we spoke with told us that they felt safe when they received support from the care staff. One person told us, "I feel safe." Another person said, "I did feel safe." They went on to explain that there had been a problem with the fire alarm that had unsettled them. The registered manager explained that staff had remained with people and reassured them while the fire alarm had been fixed. A relative told us, "[Person's name] is definitely safe."

Staff members we spoke with had a good understanding of types of abuse and what action they would take if they had concerns. All staff we spoke with told us that they would report any suspected abuse immediately to the manager or to external professionals if necessary. Policies and procedures in relation to the safeguarding of adults were in place and the actions staff described were in line with the policy. Staff told us they had received training around safeguarding adults. Records we saw confirmed this. Staff we spoke with told us that they understood whistleblowing. They felt they could raise concerns and knew the procedure for this. The registered manager had an understanding of their responsibility to report allegations of abuse to the local authority. However they did not always report these allegations to the Care Quality Commission which they are required to do. We saw that the registered manager had reported concerns appropriately to the local authority safeguarding team and the concerns had been investigated either internally when this had been requested by the local authority or by the local authority.

People's care plans included risk management plans and control measures to reduce the identified risk. These were individualised and provided staff with a clear description of the identified risk and specific guidance on how people should be supported in relation to this. These included assessments about moving around the home safely and where a person was unable to use a call bell. Risk assessments were reviewed quarterly unless a change had occurred in the person's circumstances. This was important to make sure that they information included in the assessment was based on the current needs of the person. Some people displayed behaviour that could have caused harm to themselves and others. We saw that guidance in care plans recorded actions that the staff should take to minimise the behaviour and the risk of harm. Staff knew how to offer safe support should this have occurred. This meant that staff understood and knew how to respond to people's behaviours.

Where accidents or incidents had occurred these had been appropriately documented and investigated. The documentation included a detailed description of what had happened. Where these investigations had found that changes were necessary in order to protect people, these issues had been addressed and resolved promptly.

People were protected from the risk of harm because there were robust contingency plans in place in the event of an untoward event such as large scale sickness or accommodation loss due to flood or fire. Staff knew the fire response procedure and this was practised to make sure that everyone knew what to do in an emergency. Personal emergency evacuation plans were in place for people living at the home. These provided a guide for staff and emergency workers in regards to the assistance people required in the event of a fire. We saw that regular testing of fire equipment took place.

People told us that they felt that there were usually enough staff although sometimes they had to wait. One person told us, "They can take a long time to get to you if you need the toilet." Another person said, "You often have to wait. Normally it is reasonable." Relatives felt that there were enough staff. A relative commented, "There's always a lot of staff." Staff told us that they felt there were enough staff to meet people's needs. One staff member said, "There are enough staff. We have a number of people with quite high needs but we are not rushed off our feet." Another staff member commented, "There are enough staff. It is very busy." The rota showed that suitably trained and experienced staff were deployed so that there were a suitable number of staff on each shift. The registered manager told us that they used a dependency tool to review staffing levels against the needs of the people who used the service. They told us that this was reviewed monthly and showed that the staffing levels were appropriate to safely meet the needs of the people who lived at the home. We found that staff had time to talk with people and support people when they asked for this.

People were cared for by suitable staff because the provider followed robust recruitment procedures. Staff had undergone detailed recruitment checks as part of their application process and these were documented. We looked at the files of four staff members and found that all appropriate pre-employment checks had been carried out before they started work. These records included evidence of good conduct from previous employers, and a Disclosure and Barring Service (DBS) Check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who used care services. This meant that people could be confident that safe recruitment practices had been followed.

People received their medicines safely because arrangements were in place for the safe storage, administration and disposal of medicines. One person said, "They give me my tablets every day. I ask for pain killers and can have them." Another person commented, "I have tablets. They give it to me every day." The service had a policy in place which covered the administration and recording of medicines. Staff told us that they felt confident with completing the tasks related to medicines. They told us that they had been trained to administer medicines. We saw that staff completed training and were also assessed to make sure that they were competent to administer medicines. Each person who used the service had a care plan around medicines to determine the support they needed and a medication administration record to record what medicine the person took. Where someone had a 'PRN' medicine we saw that a protocol had been written so that staff knew when this could be taken. PRN medicines are prescribed to be taken only when they are required. We looked at the records relating to medicine and found these had been completed correctly.

Good

Is the service effective?

Our findings

People and their relatives were positive about the ability of staff to meet each individual person's needs. One person told us, "They seem to know what they are doing." Another person said, "The people looking after us are good." A relative commented, "They know what he likes. They know they don't give him tea without sugar." A relative told us, "[Person's name] has not had a fall since being here. He has to be hoisted. The staff do that well."

People were supported by staff who received an induction into their role. Staff told us that they had a detailed induction. They described how they had been introduced to the people they supported and said they had been given time to complete training, read care plans and policies and procedures. The staff also said that they had shadowed more experienced staff before working alone with people using the service. Records we saw confirmed that staff had completed an induction. We saw that the provider used the Care Certificate for newer staff members. The Care Certificate was introduced in April 2015 and is a benchmark for staff induction. It provides staff with a set of skills and knowledge that prepares them for their role as a care worker.

People were supported by well trained staff. We looked at the training records. These showed that staff had completed a range of training including specific courses for the needs of the people who they supported. The staff we spoke with told us that they felt that they had completed adequate training to enable them to carry out their roles and that training was of good quality. One staff member told us, "I have done lots of training. If I want to do anything I can ask." Another staff member commented, "The training is good quality. I have done enough. If I want to do more I can always ask."

People were supported by staff who received guidance and support in their role. There were processes in place to supervise all staff to ensure they were meeting the requirements of their role. Supervisions are meetings with a line manager which offer support, assurance and learning to help support workers develop in their role. Staff told us that they had regular supervision meetings and felt supported. One staff member told us, "I have face to face and observational supervisions." Another staff member commented, "I have supervisions and appraisal meetings where we set goals. There is always someone we can get in touch with if we need to." Records we saw confirmed that supervisions had taken place and these were both face to face meetings and observational supervisions where staff were seen while completing part of their role. We saw that if there were any concerns with a staff member's practice, the registered manager or senior care staff addressed this as part of the supervision meeting. This meant that staff had received guidance on how to provide effective support to people.

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 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 the Deprivation of Liberty Safeguards (DoLS). 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.

We found that DoLS applications had been made for a number of people. The registered manager and staff showed an understanding of DoLS which was evidenced through the appropriately submitted applications to the local authority.

Staff were able to demonstrate that they had understanding of the MCA and that they worked in line with the principles of this. They were confident discussing the principles of the MCA and what it meant in practice for the people they supported. This involved supporting people to make their own decisions and involving others when this had been needed. One staff member told us, "Where people don't have capacity we make decisions in their best interests. Some people have got DoLS agreed. I always ask for consent." Another staff member commented, "It is important to respect people's wishes. We know what people like and offer them options." A staff member said, "I would respect the person's decision. I wouldn't make someone do something they don't want to."

We found that mental capacity assessments had been completed where it was believed that a person did not have the capacity to consent to a specific decision. Records showed that the registered manager was able to respond appropriately when people were not able to make decisions that could affect their wellbeing and did not have relevant person to act on their behalf. This included involving health and social care professionals in best interest decisions regarding people keeping safe. However, in two people's records a relative had signed the care plan to consent to care on behalf of the person where they did not have a legal authority to do so. A person can only make decisions on behalf of someone else where they have a Legal Power of Attorney. We discussed this with the registered manager and the manager who agreed that they would review this with each person. In these ways people's human rights were protected.

People told us that they enjoyed the food. One person said, "The food is good." Another person commented, "The food is nice." One person said, "The food is bland." Another person told us," "I can always ask for something different." A relative told us, "The food is presented well." People were supported to have sufficient amounts to eat and drink to maintain a balanced diet. We saw a menu was available with choices for each meal and this was based on what the people who used the service liked to eat. Throughout the day drinks were available in the communal areas. Where someone required specialist equipment such as a plate guard this was provided. We saw that staff supported people where they needed assistance to enable them to eat safely. The cook told us that they were in the process of recording each person's favourite food and pudding to add these to the menu. We saw that people were able to have alternatives if they did not want the food that was on the menu.

People were supported to maintain good health and access health care services when needed. One person told us, "The doctor has been regularly. I've seen him in the past." Another person said, "I can see a doctor if I need to." A relative said, "They get the doctor where needed." We saw that people were referred to health professionals when appropriate, such as when they had a problem with their skin. People's healthcare was monitored and where a need was identified they were supported to visit the relevant healthcare professional. Records showed that information from health appointments was recorded. We saw that care plans contained contact details of people's relatives, GP or other involved health professionals so that staff able to contact them if needed. The registered manager told us that the doctor held a regular surgery at the home each week. They told us that a list of people who wanted to see the doctor was sent to them prior to

the surgery so that their notes were available. This meant that people's health and well-being was promoted.

Good

Is the service caring?

Our findings

People were mostly positive about the support that they received and the caring nature of staff. One person told us, "The people looking after us are good." Another person said, "Some of the staff are really good. The majority are kind." One person commented, "Sometimes the staff ignore me. Only certain ones." Another person told us, "The staff are always kind and caring. They are friendly." A relative told us, "The staff are all very friendly. They talk to us." A staff member commented, "I really enjoy it here. It is like my second family. I enjoy trying to make sure people have a full life. All of my colleagues are very caring."

People were treated with dignity and respect. We observed staff interacted with people in a caring compassionate and kind manner throughout the inspection. This included laughing and joking with people. We heard light hearted conversations which led to laughter and joking. We saw that staff spent time chatting to people and took an interest in them. Staff told us how they protected people's privacy and dignity. This included closing doors, covering people while they had personal care and knocking on doors. One staff member said, "I treat people how you would want to be treated. It is someone's family member. Treat them like a loved one."

People's preferences and wishes were taken into account in how their care was delivered. For example, routines that they wanted to follow were respected. Information had been gathered about people's personal and medical histories, which enabled staff to have an understanding of people's backgrounds and what was important to them. Staff knew about the people who used the service. Staff described how they read people's support plans to know people's preferences and what was important to them. One staff member said, "I know people well. We can always ask the person or their family if we want to know something although it is in their care plan." Another staff member told us, "We get to build relationships with the people. It is all about the residents." We saw that each person had a document called 'All about me'. This had been completed with the person and included information about personal history, family and what the person enjoyed. This meant that staff had access to detailed information about each person and what mattered to them to help them build relationships.

People were sometimes involved in planning their own care. One person told us, "I have heard of a care plan. But I have never seen it." Another person said, "I know what a care plan is. I'm not sure if I have one." A relative commented, "There is a care plan in place. I talked it through with them." Staff told us that they tried to get information from the person or their family. One staff member said, "It is important to ask the person or their family so we find out what is better for them." We saw that people had signed their own care plans where they were able to and had been involved in providing information about what was important to them, how they liked to do things and routines they preferred to follow. The registered manager told us that people were involved in planning their own care and day to day decisions about what they did. Records showed that people had been involved in decisions about their support.

People's independence was promoted. One person told us, "I have got all of my faculties. I do lots of things for myself and they know that." A relative said, "[Person's name] has pureed food. They let him feed himself even though it makes a mess. They are here to enable not disable and it gives [person] something to do." A

staff member told us, "We try to maintain independence for people." Another staff member said, "I always get people to do things for themselves that can. Such as wash what they can." We saw that care plans recorded what people can do for themselves and what they needed help with. This meant that staff enabled people to maintain the skills they had.

People's visitors were made welcome and were free to see them as they wished. One person commented, "Family can visit when they want." A relative told us, "I visit regularly. They make us feel welcome."

People's personal information was being handled confidentially. We saw that the provider had secure lockable cabinets for the storage of people's care records. We heard staff share information about people in a discreet and sensitive way so that conversations were not overheard by others. We also saw that the provider had made available to staff confidentiality and data protection policies. This meant that people's privacy was being protected by a provider who had suitable procedures and by staff who knew about these.

Good

Is the service responsive?

Our findings

People were supported by a service that was responsive to their needs. We found staff knew people well and were able to discuss their needs and individual circumstances with us. One person said, "The staff help me in a way that I like." Another person told us, "Staff help me with everything." A staff member told us, "if I need anything for a person. I just have to got the management and ask. They provide things to make people's lives better."

People had been involved in an initial assessment of their needs before they moved to the home. We saw that the assessment asked for information about what was important to the person, including what they liked and disliked. Information had also been sought from their relatives and other professionals involved in their care. Information from the assessment had informed the support plan. This meant that people were involved in planning their care. Records showed that people and their families had been involved in reviews of people's care. Relatives were involved in decisions with the person's consent. A relative told us, "I was involved in the care plan." The registered manager told us that they aimed to hold reviews with the person and their relatives at least twice a year. We saw that on the day of our visit two reviews were held and family attended these. This meant that people were regularly given the opportunity to discuss their care and any changes they would like to happen.

Peoples care plans contained personalised information that made it possible for staff to know how they wanted to be cared for. We saw that people's routines were recorded along with information about people's likes and preferences. For example, in one care plan we read, 'I like to have a duvet on my bed to keep me warm. I like one pillow.' We found that people had signed their own care plans where they were able to do this.

People's care plans included information about planning for the end of their life. We saw that a document called 'support with end of life' that some people have completed. This contained information about what the person wanted to happen when they were nearing the end of their life and they type of ceremony they wanted to have. This meant that people had been supported to discuss what they wanted to happen at a very important time of their life so that their wishes were recorded in advance. The registered manager told us that people only completed these when they wanted to and it gave people reassurance that their wishes were known.

People were offered a limited range of activities to provide them with stimulation. However the registered manager told us that they were in the process of recruiting an activities co-ordinator. People we spoke with were unsure if they participated in activities. One person said. "There's nothing to do in the daytime. There used to be a girl but she has gone. I sometimes go out but it not often. "Another person said, "Activities? No nothing. I just sit here. They have tried with visits out but if that doesn't suit you I just go to sleep." One person said, "There are no activities at all." Another person commented, "I love to get out and I don't have the chance. She left (the activities worker)." A relative said, "They don't have daily activities. There is a lot of people and I think it may be expensive."

We saw that there were planned activities for each day. However, on the day of our visit the planned activity did not take place. We saw that some people were involved in a game with staff in the afternoon. The staff told us that they tried to offer people activities when they could. "One staff member said, "I try and do things with people such as painting nails or colouring." Another staff member told us, "I try to spend time with people and do activities. I did get chance to sit with someone and do their nails." One staff member commented, "If it is not so busy I like to ask people what they want to do." We spoke with the activities manager who was at Langdale Residential Home on the day of our visit. They told us, "If the activities co-ordinator is not here we try to get staff to do something." The activities manager told us about activities that had taken place. These included animals being brought into the home so people could spend time with these, film afternoons, a weekly trip to a local church group, fetes where people from the local village were invited, food themed evenings, and trips to events such as Crufts dog show. The activities manager told us that records were kept for each person to show what they liked and activities they had participated in. Records we saw showed that people had participated in some activities. The activities manager said that they wanted to display pictures from activities and art work that people had completed around the home as a reminder of what they had done.

Handover between staff at the start of each shift ensured important information was shared, acted upon where necessary and recorded. This ensured people's progress was monitored and any follow up actions were recorded. The handover was recorded so that all staff could see a record of what had happened. Key information was recorded in the communication book that all staff could access.

Staff knew how to support people if they became upset or distressed. We saw from one person's support plan that they could become anxious. The care plan identified examples of how to identify the triggers for the behaviour and de-escalate this behaviour. Staff were able to explain these to us. This meant that staff were able to support people effectively when they were upset or distressed.

People told us that they didn't know how to complaint but they would speak with staff or the registered manager if they were worried or had any concerns. One person said, "I don't know how to make a complaint but I would speak to the manager I guess." Another person told us, "I have had to make a complaint. I spoke with the staff." A relative told us, "I would complain if I needed to but I don't know the procedure." There were procedures for making compliments and complaints about the service. This was displayed but people were not aware of this. The registered manager told us that they would remind people of the procedure. We saw that all complaints that had been received had been logged and responded to within the timescales in the procedure.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was aware of most of their registration responsibilities. Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. The registered manager did not always inform us about incidents that had happened. For example, We found four incidents where there had been a potential safeguarding incident for people who used the service. From the information provided we were able to see that appropriate actions had been taken, the local authority had been informed and investigations had been completed. However, the statutory notifications to us had not been completed. We have taken this into account when we made judgements in this report. The registered manager told us that they would make sure these notifications were made in the future.

People told us that they had not been asked for feedback on the quality of the service. One person said, "Feedback. They don't ask you." Another person told us, "They haven't asked me for feedback." A relative commented, "I'm not asked for my views." We found that a survey had been sent out to people who used the service and relatives in April 2016. The outcomes from the 2015 survey were positive. The registered manager told us feedback from the surveys was provided as a summary for people. They told us that if there were any specific concerns raised that these were addressed directly with the person to resolve them. We also saw that a satisfaction survey had been sent in December 2015 and comments cards called 'Your voice is heard' had last been completed in September 2015. These cards had simple questions on to ask people for their opinion on the care they received. The registered manager told us that people had casual residents meetings and discussed activities, and what they would like on the menu. They told us that they had tried to hold a relatives meeting but this had been poorly attended. The registered manager told us that they held a surgery once a month where relatives could pop in and speak directly with them. They said that they also had an open door policy so people could talk to them at any time. We saw a sign on the office door that informed people about the surgery and about the open door. We discussed the feedback we received where people did not feel that they had been asked for their views. The registered manager told us they would try and find a way to display the feedback so that people had a reminder of this.

People told us that they were pleased with the service provided and the way it was managed. One person told us, "It's very good here." Another person said, "This is the best home out of the lot in the Midlands." One person commented, "I like it here." A relative told us, "I think it is really good. It's got a happy feel about it. I would definitely recommend it." A staff member told us, "They make people's lives better." The service had an experienced registered manager and a manager who was applying to become the registered manager. We received positive feedback about how they managed the service and supported the staff. Staff spoke highly of both the registered manager and the manager. One staff member told us, "I can approach the managers and talk to them. They are very open and they listen." Another staff member said, "The managers listen to staff. I can't praise them enough." One staff member told us, "There is always someone available even on the phone. The manager is very approachable and they support us. They let us know when things change." The management structure in the home provided clear lines of responsibility and accountability. The manager was supported by the registered manager and the provider. They had support from a deputy manager, registered nurses, senior carers, and a team of care workers. Staff told us that the registered

manager or the manager was always available and that they spent time in the service to see how people were. We saw staff and people who lived at the service were comfortable speaking with them.

Records were well maintained at the service and those we asked to see were located promptly. Staff had access to general operating policies and procedures on areas of practice such as safeguarding, the MCA, whistleblowing and safe handling of medicines. These provided staff with up to date guidance.

The provider regularly monitored the quality of care at the service. The registered manager told us that the provider visited at least twice a month to complete building checks and environmental checks. The registered manager carried out audits every three months on areas such as training, paperwork, health and safety, and supervisions. We saw that audits were completed monthly by the manager and the deputy manager that looked at incidents that had happened and any cases where someone had developed an infection to try and identify any trends and put measures in place to avoid a reoccurrence. We saw that actions plans were put in place to identify any areas that needed addressing. This meant that the service had processes in place to monitor the quality of the service and drive improvements in the delivery of a quality service.

The management team had taken part in research projects to improve the care for people. They had participated in a project that looked at people who were living with Dementia participating in walks and the positive impact this had on them. The registered manager told us that they got involved with research projects to see if the ideas and initiatives were suitable for the people living at the service to improve their care.