Leonard Cheshire Disability

St Michael's - Care Home with Nursing Physical Disabilities

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

St Michael's - Care Home with Nursing Physical Disabilities is registered to provide accommodation and nursing care for up to 36 people including people who require respite care. The home specialises in the care of people who have a physical disability. Most people at the home have complex needs in addition to their physical disability and as a result many of them have limited communication skills. At the time of our inspection there were 34 people living at the home. The home is a large building over three floors. There are communal lounges, a dining room and spacious grounds. The home has a chapel and bar area often used for social events in the evening. There is a physiotherapy area including a gym space and room where the activity team are based.

This inspection was unannounced and took place on 17 and 18 August 2016.

The home 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 relatives told us they felt safe. Most of the medication procedures in the home were safe but there was a risk staff would not know where guidance was for people who needed medicines 'as required'. Medicines were stored safely.

People who required special diets received them and staff understood about special diets to meet people's care and health needs. But one person was found with an un-thickened drink which led them to cough and had not been given the option to have it thickened.

Staff were supervised and received enough training to meet people's needs.

A safe recruitment procedure was in place and staff received checks before starting to work with people.

Staff knew how to recognise and report abuse. They had received training in safeguarding adults from abuse and knew the procedures to follow if they had concerns.

There were sufficient staff available to enable people to take part in a range of activities according to their interests and preferences. The registered manager was currently recruiting more staff because they had identified people's needs were changing.

People's health care needs were monitored and met. The home made sure people saw the health and social care professionals they needed and implemented any recommendations made which people agreed to.

Staff and the registered manager had understanding about people who lacked capacity to make decisions

for themselves. However, some people had not had their records updated when they lacked capacity to be in line with the code of practice. Staff understood about Deprivation of Liberty Safeguards (DoLS) and the process to follow to make sure people's human rights were respected.

Staff supported and respected the choices made by people. People's diversity was respected. People had a choice of meals, snacks and drinks, which they told us they enjoyed.

People and their relatives thought the staff were kind and caring and we observed positive interactions. People's privacy and dignity was respected.

Staff had good knowledge about people's needs. Their care plans had met national standards for end of life care which helped to ensure best practice for people when nearing the end of their life. The needs of the people were reflected in their care plans.

Some audits were being completed by the registered manager and provider to identify shortfalls. They had both recognised further improvements were required to make the audits more comprehensive. When shortfalls had been identified the registered manager resolved them. There were systems in place to manage complaints and the registered manager demonstrated a good understanding of how to respond to them.

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's medicines were managed safely but medicine records were not always correct and there was a lack of guidance for staff when people needed medicines 'as required'.

People were protected from abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to make choices and participate in activities they enjoyed.

People were kept safe and had their individual needs met because there were sufficient numbers of suitable staff deployed.

Is the service effective?

Good

The service was effective.

Most people who lacked capacity had their human rights considered and respected.

People were supported to see appropriate health care professionals to meet their specific needs.

People made decisions about their day to day lives and were cared for in line with their preferences and choices.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

Is the service caring?

Good

The service was caring.

People told us that they were well looked after and we saw the staff were caring.

People were involved in making choices about their care.

People's privacy and dignity was respected.

People's religious needs were considered.

Is the service responsive?

Good

The service was responsive

People's care plans were detailed and they covered all aspects of their care and needs.

People participated in activities and where possible the activities team tailored them to meet individual needs.

People received care and support in line with care plans and staff were familiar with the information in the care plans.

People knew how to make complaints and there was a complaints system in place.

Is the service well-led?

Good

The service was well-led.

There was a developing quality assurance programme in place which was being improved by the provider and registered manager.

The registered manager had a clear vision for the service and this had been adopted by staff.

The staffing structure gave clear lines of accountability and responsibility and staff received good support.

St Michael's - Care Home with Nursing Physical Disabilities

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 17 and 18 August 2016 and was unannounced. It was carried out by one adult social care inspector and a specialist advisor nurse. The specialist advisor nurse had a background in and experience of working with people with physical disabilities.

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. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

We spoke with four people that lived at the home in detail, three visitors and had informal conversations with five other people at the home. We spoke with the registered manager and 10 members of staff including kitchen staff, laundry staff, nursing staff, activities staff and care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people could not talk with us. Following the inspection we spoke to three of the provider's staff on the telephone.

We looked at six people's care records and observed care and support in communal areas. We looked at five staff files, previous inspection reports, staff rotas, quality assurance audits, staff training records, the

complaints and complements files, staff and resident meeting minutes, medication files, staff and people's questionnaires, environmental files and a selection of the provider's policies.

Good

Is the service safe?

Our findings

People told us they felt safe at the home but some shortfalls were found with medicines administered 'as required' and one person whose drink was not thickened correctly. People said, "I feel safe" and they were "Happy", whilst others nodded when they were asked if they felt safe. Relatives we spoke with told us they felt staff were keeping their family members safe. They were positive about what the staff had done to keep their family members safe.

Some people required specialist diets and thickened drinks due to their health conditions. Staff identified and provided food for people who required these to prevent them choking. We saw one person receiving an assessment from a health professional in relation to requiring a textured diet. Some people required thickened fluids or different textured meals when they had difficulty swallowing. Meals were adapted for people who required low sugar diets or meals of a different texture. By doing this staff were recognising how to keep some people safe and healthy when they had specific dietary requirements. However, on the first day of inspection we saw one person coughing after every sip of tea they were drinking. The person had not been given the option to have their drink thickened as recommended by a health professional to prevent fluid from passing into their lungs. No members of staff checked the person was alright. Two staff were not familiar with a health professional's advice from July 2016. We spoke with the registered manager who showed us there had been training and supervisions for staff around special diets and thickened drinks. They told us it was essential for many of the people because of their complex medical diagnosis. The registered manager confirmed as some staff were unconfident they would make sure all staff received training including refresher training for staff involved. Following the inspection the provider showed us a disclaimer which had been signed by the person choosing not to have their drink thickened in line with advice.

There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. We saw the provider used medicine administration records (MAR). MAR is when a member of staff signs a chart to identify they have administered a specific medicine. We noted medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave an audit trail for most medicines and enabled the staff to know what medicines were on the premises. There were three occasions when it was not recorded when creams had been administered. Also, there was not always a running record for 'as required' medicines to show how much stock was left. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately stored and clear records were in place. We checked records against stocks held and found them to be correct. Some people required medicines administered by mixing them with a food or drink. This was because they had complex needs which may make it difficult to take medicine any other way. The correct process of seeking consent and administering medicines like this was followed. This meant people's medicines would work as per the manufacturers guidelines and they would be safe.

Some people unable to communicate were prescribed medicines on an 'as required' basis. This is medicine which is not required at regular intervals. People were receiving these medicines from regular staff. Guidance was kept in people's care plans and not with the medication administration records to inform staff

when or why these medicines should be administered. Nurses told us they just knew when a certain medicine should be given. There was use of agency and bank staff who may not be familiar with where the guidance was kept and unable to ask some people.

People were supported by sufficient numbers of staff to meet their needs. During the inspection we saw when people required a member of staff they only had to look for a short time before they found one. People were supported by staff at meal times even if two members of staff were required. This meant people had their care needs met when they required support from staff. However, some people accessed the community with a member of activity staff which left one to run the rest of the activities. We saw there were limited activities occurring in the service due to this. When a member of staff was asked about whether there was enough staff they told us "It would be nice to have more". We spoke with the registered manager who explained they had enough staff to meet people's care needs. They showed us the provider's dependency tool which demonstrated how they had identified the staff numbers to meet people's needs. They realised some more staff would reduce the workloads of present staff and increase the activities because care staff could help. They explained there was a recruitment drive for care staff.

Care plans contained risks assessments which outlined the measures in place to enable people to take part in activities with minimum risk to themselves and others. These were put in place as soon as each person moved into the home. People were supported to take risks such as participating in certain activities in the community. For example, people went punting on a river and horse riding. Records showed these risk assessments had been regularly reviewed to ensure they remained up to date. By having clear risk assessments the provider was able to demonstrate when people had chosen to make their own decisions they were respected. For example, one person, with capacity, had a risk assessment completed because they had decided not to follow advice recently given by a health professional.

Staff told us, and records seen, confirmed all staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. They were able to tell us who they would speak with and some staff described different types of abuse they had to be aware of. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were kept safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

Risks of abuse to people were minimised because there was a robust recruitment procedure for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults. Staff we spoke with confirmed they had checks prior to starting work including a Disclosure and Barring Service (DBS) check. A DBS check is to make sure staff do not have a criminal record and are not barred from working with vulnerable adults. The provider had made sure there was photographic identification for each member of staff and there had been contact with previous employers for satisfactory references. Staff members told us and records showed no staff member had started work prior to all the checks being completed.

People were kept safe because the home had a strong system for infection control. Infection control is when policies and procedures are used to minimise the risk of infections spreading. Due to the complex needs of people the registered manager and staff had identified the importance of having good infection control systems. The registered manager had set up an infection control committee to assess and reduce risks to people. This had been part of their plan in the PIR. One of the nurses had a special interest in a specific type of infection and had implemented a screening tool to help identify people at risk of this. By doing this people's risk of infection was reduced because staff were constantly finding preventative measures to keep them safe. For example, special filters on taps and shower heads were in place for two people who were

prone to a specific infection. The registered manager and staff had reduced the level of hospital admissions through these actions.

Good

Is the service effective?

Our findings

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. Decisions made in a person best interest consider what the person would choose if they had the capacity. We checked whether the provider was working within the principles of the MCA.

Most people who lacked capacity had their human rights considered and respected. Where it was required, health and social care professionals and relatives were involved in making specific decisions in people's best interest. For example, it was decided it was not in a person's best interest to have a blood test because of the distress it could cause them. Other less invasive decisions were taken such as monitoring the person's health. A health professional and the person's relatives were involved in making this decision. Staff had an understanding of the MCA and how to make decisions in people's best interest. Some people's MCA assessments and best interest decisions had not been recorded in line with the MCA. We spoke with the registered manager who explained they had been swapping from an old format of MCA recording to a new format. We saw the new format during the inspection which was in line with the MCA. People were always asked for their consent before staff assisted them with any tasks.

People can only be deprived of their liberty so they can 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 conditions on authorisations to deprive a person of their liberty were being met. The appropriate applications to the local authority had been made when people were being restricted, which could result in a deprivation on the liberty. Two people had a DoLS authorisation in place with no conditions the home had to follow.

People received care and support from staff who had the skills and knowledge to meet their needs. One member of staff said, "I have learnt more here" when comparing training to other places they had worked. Another member of staff told us how they helped to deliver specific training and refreshers to other staff. They also told us they had been enrolled on a specialist health and social care qualification. Staff had received training in a range of areas to help them support people with complex needs. This included emergency first aid, nutrition and hydration, fire safety, and infection control. Additional training was delivered for specific health conditions. There were annual competency checks for staff who administered medicines to make sure they were doing this safely. The registered manager showed us their plan for staff who were due refresher training and staff they had identified required training. By having these clear plans in place they were aware of shortfalls and had systems to rectify them.

People were supported by staff who had undergone a thorough induction programme which gave them the basic skills to care for people safely. Staff told us they had completed 'shadow shifts' and worked alongside more experienced staff when they started working. The provider had been introducing the Care Certificate into the induction for all new staff. The Care Certificate is a set of standards created by Skills for Care which

all health and social care workers should follow in their daily work. It is the new minimum standards that should be covered as part of induction training for new care workers. The provider had recognised the importance of these standards so had been introducing them six months prior to becoming a requirement for all new health and social care workers.

There were always qualified nurses on duty to make sure people's clinical needs were monitored and met. The nurses were responsible for leading shifts and directing care staff. Some nurses were responsible for supervising care staff. They led comprehensive handovers when a new shift started so important information was passed on. This was an opportunity for any changes to people's care needs to be shared from the nursing staff to the care staff. It was important the information was passed over in this way because care staff were not as actively involved in writing care records as the nurses.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. We saw people chose where they would like to eat the meals. For example, one person had a conversation with a member of staff about where they wanted to eat. Their choice was respected by the member of staff and at lunchtime they ate in their chosen place. People told us they liked the food and we saw others laughing and joking with staff during their meal. There were choices for main course and pudding.

People were involved in menu planning. One person told us "There had been a menu meeting not long ago". This was an opportunity the registered manager had provided for people to speak with the chef about their food preferences and menus. At this meeting people suggested they would like more food from different countries. Following the meeting, a new set of menus were created which contained Indian, Italian and Chinese food. Another preference was to have the option of yoghurts for pudding. During the inspection yoghurts and fresh fruit were offered as pudding options. When people did not want the options which were available kitchen staff prepared food to meet their preferences. For example, one person preferred prawns and potatoes for most of their meals and this had been provided at lunchtime.

People who wished to lose weight told us staff had organised for dieticians to be involved in their care. One person told us staff had helped them lose four stone as part of their weight loss plan. Another person explained they liked food but had been encouraged to eat three meals a day to stay healthy. This meant staff were supporting people to remain healthy and eat a balanced diet to support weight loss.

The provider told us in their PIR people had regular access to health and social care professionals. We found the provider arranged for people to see health care professionals according to their individual needs. During the inspection a dentist, speech and language therapist and oral hygienist saw specific people to complete health assessments or provide treatment. When people had not been feeling well staff had arranged for them to see health professionals.

All people living at the home had physical disabilities. Every week there was a physiotherapy visit This was to ensure people with complex physical difficulties were having their needs met. There was a physiotherapy assistant to help people on days when the physiotherapist was not available. In part of the home there was a physiotherapy studio and a small amount of gym equipment. As part of their physiotherapy programme people were able to use them to meet their health and well-being needs.

Good

Is the service caring?

Our findings

People said they were supported by kind and caring staff. One person told us staff were "Very kind". Another person told us staff listened to them, were "Very helpful" and "Very nice". Throughout the visit most people were smiling and interacted positively with the staff. Members of staff responded to people promptly and found out how they could help them. One relative explained staff were caring. A member of staff told us it was important they listened to people.

People's privacy was respected and all personal care was provided in private. Personal care is when people are helped with intimate tasks such as washing and dressing. One person told us during their shower they were given choice and if you wanted a shower chair this was provided. They said they "Feel comfortable" whilst being supported. Staff knew how to respect people's dignity when supporting them with personal care. Staff told us they would close all curtains and doors and ask permission before they provided support. They explained this was to protect people's privacy. They would keep the person covered as much as possible at all times. The PIR said people's choice of the gender of staff supporting them was respected. During this inspection we found this to be true. For example, one person had been distressed when personal care was being delivered but was unable to verbally communicate why. Staff took time to find out the person wanted female staff to support them with their personal care. The person had become more relaxed during personal care after their wishes were followed.

People told us they were able to have visitors at any time. Each person living at the home had a single room where they were able to see personal or professional visitors in private. One person told us they saw their parents every week. Relatives we spoke with told us they were made to feel welcome and were kept informed about their family member's care and any changes. One relative brought their child to the home and members of staff created activities for the child whilst they were visiting. If people were ill or visitors had to travel a long way there was a visitor's room, which people could use. This room was available during the day or for overnight accommodation. It was separate from the rest of the home to keep people safe.

People made choices about where they wished to spend their time. Some people preferred not to socialise in the communal areas and spent time in their bedrooms. The registered manager explained how people in wheelchairs were encouraged to be as independent as possible when moving around the home. We observed this during our inspection. When activities were due to begin, staff would go to bedrooms and ask if people would like to participate. The choices people made were respected. At lunchtime everyone was offered a choice for their main course and pudding. Staff waited for a response and allowed people to communicate what they would like in their own way. For some people this was pointing whilst others were able to say what they would prefer.

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received. One person was asked if they helped with their care plan and they nodded to us indicating they did. Other people told us there were meetings for people in their home where they could express their views and ask for changes. A relative told us they had been involved in reviews for their family member. One staff member told us one

person was unable to verbally communicate their views but had a family member visit the home daily to make sure their views were understood. This meant everyone was encouraged to express their views.

Staff were aware of issues of confidentiality and did not speak about people in front of others. When they discussed people's care needs with us they did so in a respectful and compassionate way. If the person was with us, staff made sure they were involved. Whilst we spoke with people in their bedrooms, staff knocked and waited until they were invited into the room. Staff apologised for interrupting and left as soon as they had completed their conversation. This meant staff understood the importance of respecting people's privacy when they were with a visitor. However, there were care records left in an unlocked nurse's office which was regularly unattended. By not maintaining secure records there was a risk people's information would be read by unauthorised individuals. We spoke with the registered manager and provider who said they would find a way to make sure they were kept securely.

People's diversity was respected by staff including religious differences. Staff told us they spoke with people about their religion and culture. Care plans reflected this. One staff member said, "Two Christians like to go to church" and continued to say they read the bible with them. Another staff member told us they had different vicars available to speak with people and said, "People go to the church of their choice". The registered manager had a clear vision to ensure every person's cultural and religious needs were respected. There was a chapel in the home where services were held every week for those who wanted to attend.

Good

Is the service responsive?

Our findings

People were able to take part in a range of activities according to their interests. Some people felt there could still be more community based activities. One person told us they participated in pottery and bird watching. They told us been birds of prey were brought into the home and they used a tablet computer to listen to bird sounds. Throughout the home there were pieces of pottery and art displayed which people living at the home had created. During the inspection people were taken into the community whilst others participated in an Olympic games run by the activities team. These were a range of races and events to mirror what was occurring in the Olympic games at the time of the inspection. For example, there were wheelchair races and throwing events.

Sometimes access to the community was limited by a lack of staff and space in the provider's vehicles. One person said, "There was only a certain amount of places [for a specific activity]" they continued they "Don't always get selected" by the activities team. There was an activities team leader and four activities assistants who tried to ensure all people's wishes were respected and where possible actioned in relation to activities and outings. The registered manager told us they actively looked into ways to improve this situation and ensure more people could attend communal activities. For example, they were looking into new sources of fundraising to buy more vehicles and transport alternatives such as community services.

People knew about activities because they were displayed on a timetable. Further information about future activities and trips were displayed on a noticeboard. Most people could read them because they were in a visual format with pictures and words. During the inspection the winners of medals at the home's Olympics were celebrated on the noticeboard. The registered manager continued to tell us about special events which were held at the home. This included race evenings and parties which relatives were always invited to. There were volunteers to plan and support these activities. The registered manager told us about plans to increase the number of volunteers. This was confirmed in the PIR. People we spoke with and their family members confirmed these events took place and told us how much they enjoyed them. One relative told us about the race night and spoke about betting on the horses. Their family member nodded in agreement about their enjoyment of this event.

People received care that was responsive to their needs and personalised to their wishes and preferences. Staff knew people they supported well and knew what was important to them. Where the person was unable to communicate their care needs their relatives were actively involved. A relative told us "I'm always happy with the care situation. It's good to be involved". One member of staff told us about a person's sense of humour. Another person was unable to communicate with us but had detailed information provided by a family member in their care plan highlighting their personal history, likes and dislikes. Staff we spoke with knew about people's preferences, likes and dislikes. For one person who had difficulty communicating, staff understood they were no longer able to ride horses so it made them upset if they visited stables. Therefore, their preference was to no longer visit stables and this was respected. By having an in depth understanding and knowledge of each person staff were able to provide care which met people's needs.

Each person had their needs assessed before they moved into the home. This was to make sure the home

was appropriate to meet the person's needs and expectations. Each care plan showed there had been involvement of the person and others important to them such as family members and health and social care professionals. By involving people and others close to them in their pre-admission assessment it meant people's needs could be understood, care needs met and necessary risk assessments put in place. It also meant for those who had difficulty communicating their wishes, preferences and needs were understood and met by staff.

Staff responded to changes in people's needs. People and their relatives told us they had been involved in reviews. The PIR said people had annual reviews for their care plan which involved others if it was required. We found there had been reviews which involved health and social care professionals, family members and advocates to ensure the care plan was relevant and up to date. An advocate is someone who is able to speak on a person's behalf if they have difficulty communicating their needs and wishes. When a person had a change in health needs their care plan had been updated. The information was passed onto all staff using a detailed handover sheet. By updating care plans when there were changes staff would know what support people needed.

The registered manager told us people's care plans had been reviewed as part of a big project over the last two years working towards the Gold Standard Framework. The Gold Standard Framework is an accreditation designed to ensure people nearing the end of their life received the best quality care. The registered manager showed us they had recently reviewed the care plans and had achieved beacon status. This meant the home had shown innovation and established good practice across at least 12 of the 20 standards.They said even though some people had not reached end of life they had complex needs which could result in a sudden admission to hospital. Therefore, they wanted all the care plans to be of this standard. We saw one person receiving end of life care had all the appropriate treatment and support in place to meet their needs.

The registered manager sought people's feedback on the service and took action to address issues raised. For example, a person expressed they wanted to be in a space away from others. A member of staff told us this person had been unable to communicate this verbally so had demonstrated it through their behaviour. Once their wishes had been followed they were happier and they now spent time in the manager's office rather than the main part of the house. The person was happy as they liked to spend time with the registered manager and other office staff. In addition, a computer work station had been put in the office for this person. This meant when people wanted things changed they were respected.

There were many compliments received by the home. This included a selection of cards, letters, emails and pictures. Relatives had thanked the home for looking after a family member. For example, one said, "We cannot thank you all enough for all you did to make [person's name] stay at St Michael's feel like home". Other people had complemented the home for their activities or gifts. A person had written a card saying, "Thank you all for the flowers I had for my birthday". Staff who had left and staff who had completed work placements wanted to say thank you. For example, "I've really enjoyed my time here and it has been an absolute pleasure working with you".

There were monthly meetings for people who lived at the home and their relatives. One person said they "Have residents meetings once a month". The registered manager showed us an anonymous survey which people had completed on their views of the home. Most people said they were satisfied whilst living at the home. Some people felt there could be changes to their bedroom. During our inspection the registered manager showed us one person's bedroom where the person had chosen the colours of the room and the decor. This meant the registered manager tried to be responsive to requests from people.

Each person received a copy of the complaints policy when they moved into the home. One person told us they had raised a complaint about how members of staff had supported them. They explained the registered manager had resolved their concern. Other people, relatives and staff knew who to speak with should they have a complaint and what the procedures they needed to follow were. The provider had an electronic system to manage all complaints received. The registered manager showed us a recent formal complaint which had been resolved promptly. This meant complaints were well managed.

Good

Is the service well-led?

Our findings

People, visitors and staff spoke highly of the registered manager and the support they provided. Some people said, "[The registered manager's name] is really nice" and [The registered manager's name] is very generous". We saw people came to find the registered manager in the office and smiled when they found them. When a staff member was asked about the registered manager they said, "Great. I have learnt loads from [them]. [They] are fair and open".

Quality assurance systems were being developed; some audits were completed and most checks were occurring but not always recorded because the registered manager talked us through them. The registered manager and provider had identified it was an area they were still developing. Where shortfalls had been found by the registered manager actions were taken to resolve them. For example, the registered manager had seen there was a lack of communication between the nurses and care workers so a detailed handover had been put in place. During the inspection these handovers were observed. The PIR and the registered manager told us themed supervisions had been introduced to improve staff knowledge. Staff spoken with and records seen demonstrated this improvement had occurred. This meant the registered manager and provider were resolving identified shortfalls.

There was a staffing structure in the home which provided clear lines of accountability and responsibility. The registered manager was supported by a number of team leaders including housekeeping, finance, a clinical lead and an activities coordinator. There was no deputy manager but the registered manager felt they had a good team and enough support. Staff knew they could speak with the registered manager. One staff member told us, "I always feel like I have a voice". The registered manager was supported by a number of other specialists employed by the provider. For example, an operations trainer identified when any members of staff required refresher courses or helped organise specific training and there were staff who could advise on MCA and DoLS queries.

The provider had internal systems to support the registered manager to audit the home. They completed regular visits, quarterly audits and annual reviews. During provider visits information and documents required were brought to them by staff in the home; the visits included speaking with people and staff. Following our inspection the provider decided they would spend more time going to where the documents were located. This was because all care plans were regularly being left unsecure in the nurse's office when no staff were present. The provider had not been aware of this practice. The head of quality, employed by the provider, hoped changes to the provider audits would rectify concerns like this. They explained they had only recently joined the provider so were slowly introducing changes so registered managers would be familiar with them.

Completed audits had not always identified issues found during this inspection. For example, not all MCA assessments had been completed on new paperwork. There were some missing signatures found in the medicine records. No people had missed their medicines so it was a clerical error. By not identifying and investigating missing signatures in the recording systems there was a risk people's medicines could be missed. The provider and registered manager assured us the further developments being made to improve

the auditing system would increase the checks being completed. For example, instead of just having the number of medication administration errors recorded there would be more detail collected for what each medicine audit recorded. This meant small errors would be clearly identified. The head of quality hoped this would improve the provider's checks and be able to identify anything the registered manager missed.

The registered manager told us they maintained a regular presence in the home to enable them to monitor staff performance. They were "Committed to improving the quality of care". They told us this included working some shifts alongside staff. They also told us their office door was "Always open" and they encouraged staff to talk to them about any concerns. They spoke positively about the staff team. The registered manager told us they received regular support and supervision from their manager and the provider.

The registered manager had a clear vision for the home which was to provide support for people and their families. They told us they wanted to "Ensure the best quality of life" for all people using the home. Their vision and values were communicated to staff through staff meetings and formal one to one supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. Staff told us and records seen showed regular supervisions were happening.

Significant incidents were recorded and where appropriate were reported to the relevant statutory authorities. All incidents had been entered onto a computer system and the manager explained that these were regularly reviewed by the provider so any trends or concerns could be identified. The provider had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

The registered manager was a registered nurse they kept their skills and knowledge up to date by on-going training and reading. They would liaise with other registered managers in their area to ensure their practice was up to date. The registered manager was constantly looking for ways to improve the care being delivered to people. For example, they had embedded in staff practice the Gold Standard Framework to improve end of life care plans. During the inspection, they told us the next project was 'Future Choices' because the registered manager and provider had identified long-term care planning needed to be developed in the home. Future Choices is designed to promote people making long-term goals and being supported by staff to achieve them.