Werneth Lodge Limited

# Ashbourne House Care Home

## Inspection report

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Oldham
Lancashire
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Tel: 01616241013

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01 November 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

The inspection took place on 31 October 2016 and 1 November 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Ashbourne House Care Home in October 2014, at which time the service was compliant with all regulatory standards inspected.

Ashbourne House is a care home in Oldham, providing accommodation and personal care for up to 35 older people. There were 31 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

There were sufficient numbers of staff on duty in order to safely meet the needs of people who used the service. The registered manager assessed people's dependency to ensure there were sufficient staff to meet people's needs.

All areas of the building were clean and well maintained, including external areas. Where refurbishment was required, we saw this had been incorporated into an existing action plan.

Staff demonstrated a good knowledge of safeguarding principles and what they would do should they have any concerns. People who used the service and their relatives confirmed they felt safe.

Effective pre-employment checks of staff were in place, including Disclosure and Barring Service (DBS) checks, references and identity checks.

The storage, administration and disposal of medicines was safe, in line with guidance issued by the National Institute for Health and Care Excellence (NICE) and supported by clear lines of accountability and auditing.

Risk assessments identified individual needs and staff displayed a good knowledge of the risks people faced, such as tripping, and how to reduce these risks.

People received the treatment they needed via prompt and regular liaison with external healthcare professionals such as GPs, nurses and specialists.

A training matrix was used to ensure staff refreshed their knowledge regularly. Staff had received training in Safeguarding, First Aid, Fire training, Moving and Handling, Deprivation of Liberty Safeguards/Mental Capacity Act, Equality and Diversity, Infection Control, Medication, Health and Safety and Dementia

Awareness.

Staff received regular supervision and appraisal as well as the opportunity to raise any issues at regular team meetings.

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. We found the service was working within the principles of the MCA.

The atmosphere at the home was welcoming and vibrant. The strong consensus of opinion from people who used the service, relatives and external stakeholders was that staff always behaved patiently and in a dedicated manner. We observed people who used the service interacting with staff in a relaxed and comfortable manner with staff during our inspection.

Staff had recently been trained in end of life care and external professionals confirmed the service was well prepared to provide such care, although no one was receiving end of life care at the time of our inspection.

Person-centred care plans were in place and staff also had regard to individualised signs on each person's door, which gave their name and one thing special to them. We saw regular reviews of care plans took place with the involvement of people and their family members.

Group activities took place regularly, such as in-house entertainment and parties. There was an opportunity to improve the way person-centred activities were planned and documented. The registered manager and other staff agreed the recruitment of a dedicated activities coordinator would help the service improve in this area. Relatives and people who were able to communicate their preferences confirmed they enjoyed the group activities.

People who used the service, relatives and external professionals we spoke with were generally extremely complimentary about the registered manager and the staff team as a whole. We found morale to be good and a strong team ethic in place that valued providing a good standard of care to people who used the service.

We found the registered manager undertook a range of audits and unannounced spot checks to ensure standards of care were maintained.

## 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.

Risks to people were individually assessed and the service had recently achieved accreditation for its management and prevention of slips, trips and falls.

Sufficient staff were in place to meet people's varied needs.

The administration of medicine was safe and in line with guidance issued by the National Institute for Health and Care Excellence (NICE).

### Is the service effective?

Good

The service was effective.

Staff had received a range of training relevant to people's needs and were knowledgeable regarding specific areas such as diabetes and dementia.

People's medical needs were met through regular liaison with a range of health care services such as district nurses, GPs and chiropody.

People with a range of dietary needs had their preferences met and people were complimentary about the standard and choice of food available.

### Is the service caring?

Good

The service was caring.

People who used the service, relatives and professionals all praised the caring attitudes of staff.

Consent was an integral part of care planning and delivery.

Staff had recently been trained in end of life care and were able to provide care to people at the end of their lives.

### Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and people's changing needs were identified through regular reviews, which involved people's relatives and those who knew them best.

There were a range of group activities in place, some of which were planned on the basis of people's preferences.

Regular surveys were sent to people who used the service, relatives and external professionals, and the responses were reviewed and acted on.

## Is the service well-led?

Good

The service was well-led.

The registered manager had successfully developed and maintained a culture that focussed on delivering a good standard of care to people who felt at home.

Auditing systems were in place to ensure errors were identified and rectified, and that accountability was maintained at all levels.

The registered manager maintained positive working relationships with external professionals.

# Ashbourne House 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.

We visited the service on 31 October and 1 November 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one Expert by Experience. An Expert by Experience is a person who has relevant experience of this type of care service. The expert in this case had experience in visiting services for older people and people living with dementia.

We spent time speaking with people and observing interactions between staff and people who used the service. We spoke with nine people who used the service and four relatives. We spoke with ten members of staff: the registered manager, the area manager, five care staff, two cooks and the handyman. We spoke with three visiting healthcare professionals, one social care professional and one commissioning professional.

During the inspection visit we looked at five people's care plans, risk assessments, five staff training and recruitment files, a selection of the home's policies and procedures, quality assurance systems, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by CQC. We spoke with professionals in local authority commissioning and safeguarding teams.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service

does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

Good

# Is the service safe?

## Our findings

People who used the service and their relatives consistently told us they felt they were kept safe by staff, and that risks they might face were well managed. One person told us, "The home is safe for everyone – staff make sure that people don't just wander off and if anyone wants to go out staff make appropriate arrangements." Another person told us, "I am safe here, they are all my friends here," and another said, "The atmosphere is very friendly and comforting with no fear of anybody doing harm and there is always someone available."

On arrival, we found there were sufficient staff on duty to meet the needs of people who used the service and the rota we saw indicated there were sufficient staff to meet people's needs through the night. We saw staffing levels were determined by people's levels of dependency and that this was regularly reviewed. People who used the service told us, for example, "There is always someone about," and, "I don't have to wait if I need anything." Relatives agreed there were adequate staff, as did external professionals we spoke with. During the course of the inspection we observed call bells being responded to promptly. This demonstrated people were not put at risk due to understaffing.

We saw the service had recently been awarded the gold standard for managing and preventing slips, trips and falls via the Pennine Care Foundation Trust Falls Prevention Home Care project. Risk assessments we reviewed were detailed in this regard and gave staff significant information about how to help reduce the risks of people falling. This included instructions like, for example, checking which footwear people were in and how best to communicate with the person so they understood why they were moving about the home. Other risks people faced, for example the risk of developing pressure sores, were assessed as people began to use the service and regularly reviewed.

During our inspection we observed people to be at ease with care staff. Where one person was anxious we saw staff supported them in line with their assessed needs and ensured their behaviours de-escalated through gentle distraction.

We saw the storage, administration and disposal of medicines was safe and adhered to guidance issued by the National Institute for Health and Care Excellence (NICE). We saw people's medical records contained their photograph, any allergy information and emergency contact details. We reviewed a sample of people's medication administration records (MARs) and found there to be no errors. We saw controlled drugs were securely stored. Controlled drugs are drugs that are liable to misuse. We reviewed a sample of people's administration records of controlled drugs and found it was accurate and corresponded to the controlled drugs remaining. Both controlled drugs and other medicines were subject to a daily stocktake. The controlled drugs were audited daily and the other medicines on a weekly basis. We saw feedback following a recent visit from the pharmacist which had described the systems in place to manage medicines as, "Excellent" and we found the service maintained a safe approach to the management of medicines.

People who used the service and relatives expressed confidence in the management of their medicines, with one relative telling us, "My [relative] is insulin dependent and this home is always vigilant about safety."

Likewise, when we spoke with external professionals, they were complimentary about the management of medicines. Staff we spoke with displayed a good understanding of people's medicines and we saw staff competency in this regard was reviewed every three months.

We saw the treatment room was tidy and kept locked when it was unoccupied. Medicines were housed in a locked cabinet and a locked fridge was also in use. We saw room and fridge temperatures were regularly recorded to ensure they were within safe limits. This demonstrated people were not put at risk through the unsafe management of medicines.

All staff had received safeguarding training and the registered manager was aware of the local authority's new safeguarding policy. Staff we spoke with displayed a clear understanding of safeguarding and were able to describe the risks of abuse people might face and how they would respond if they felt this was the case.

We saw appropriate pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks had been made. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We saw the registered manager had asked for at least two references, proof of ID and had completed interviews with candidates. The registered manager was in the process of renewing DBS checks for employees who had worked for the service for a number of years. We spoke with a local commissioning professional who confirmed the registered manager had liaised with them to ensure DBS checks were renewed in line with their guidance. This meant the service had a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

We found all areas of the building, including people's bedrooms, bathrooms, kitchens and communal areas to be clean and free from odours. The kitchen had been awarded a score of 5 out of 5 from the Food Standards Agency. The registered manager undertook regular walk-around checks of the service and we saw a maintenance book was used to document repairs. One person who used the service told us, "The home is immaculate", whilst one relative told us, "It's always fresh and clean." We saw there were ample and accessible supplies of personal protective equipment (PPE) such as gloves and aprons, as well as alcohol gel dispensers.

With regard to the premises we saw Portable Appliance Testing (PAT) and periodic electrical testing had been undertaken, whilst the boiler had been serviced. The fire alarm and emergency lighting were tested regularly, as was the nurse call system, whilst fire extinguishers had been serviced. We saw lifting and hoisting equipment had been regularly tested and service in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). The lift malfunctioned during our inspection but was fixed within two hours. Water temperatures were regularly checked to ensure people were not at risk of scalding. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

We saw incidents and accidents were documented and recorded in such a way that made it easy to identify any trends that might develop.

We saw there were personalised emergency evacuation plans (PEEPs) in place, which detailed people's mobility and communicative needs. These were easily accessible in a communal area and easy to follow. These also corresponded to a colour coding on the top of people's door, which indicated whether they required full, some or no assistance to evacuate the building. This meant members of the emergency services would be better able to support people in the event of an emergency.

Good

# Is the service effective?

## Our findings

We found people who used the service were cared for by staff who had the training and support required to help people experience care suitable to their needs. One person who used the service told us, "Staff are alright – they know what they are talking about and they do support everyone."

One visiting professional told us, "They always know the resident really well. They can always give me a proper history." Other external professionals we spoke with confirmed they had confidence in the knowledge and ability of staff at the service. One told us, "Staff always give me an update. If there's something specific they're not 100% on they will always ask, so between us we can iron out any concerns."

Visiting professionals agreed that staff knowledge of people living with dementia and how they could better support them on a day to day basis was good. One professional told us, "They are well set up for dementia. Staff are patient and build up a good understanding." We saw all staff had received dementia awareness training and, when we spoke with staff about the impact of this training, they gave examples of how it helped them care for people, such as speaking particularly slowly to one person, and linking arms with another when walking with them, in order to reassure them and reduce anxiety.

Staff training was planned via a training matrix and we saw staff training was up to date. Training the provider considered mandatory included Safeguarding, First Aid, Fire training, Moving and Handling, Deprivation of Liberty Safeguards/Mental Capacity Act, Equality and Diversity, Infection Control, Medication, Health and Safety and Dementia Awareness.

Staff demonstrated a good knowledge of one person's diabetic needs and we found their responses were in line with the person's diabetes care plan, which was supported by additional guidance documentation regarding what warning signs to look for and how best to support the person. When we spoke with a district nurse they told us, "They are pretty clued up on diabetes, I must say, and staff are usually able to give me a good update." We also saw documentary evidence this person received regular visits from the district nurse. This demonstrated that staff had the relevant knowledge to help provide appropriate care to people and ensured they were supported by external healthcare professionals.

We saw people with specialised diets had their needs met and the cooks demonstrated a good knowledge of people's dietary requirements, as well as preferences. People who used the service were complimentary about the food. One person said, "I am content with all my food – they feed you very well and I like fish or prawns." One relative told us, "There is always enough good food and my [relative] is a fussy eater, so the staff do well." People who used the service and relatives confirmed people could choose something not on the menu if they preferred, as well as choosing to eat in their room.

We saw the menu was a four-week rolling format, with choices at each meal and a pictoral menu to help people choose. One person told us, "You always have an idea of what you're choosing, so you never get it wrong," whilst another confirmed they found the pictures helpful. We also saw refreshments and snacks were regularly offered to people who used the service throughout the days of our inspection.

People's weights were regularly monitored using the Malnutrition Universal Screening Tool (MUST). This is a screening tool using people's weight and height to identify those at risk of malnutrition.

We found the dining experience to be pleasant, with staff interacting with people in a patient and personable manner, supporting people who required help. This meant people received a nutritious diet and felt able to enjoy their meals in a comfortable setting.

All staff we spoke with confirmed they received support and supervision from the registered manager, both formal and more ad hoc. We saw evidence of staff supervisions occurring regularly, as well as annual appraisals and team meetings. Supervisions are one to one meetings between a member of staff and their manager whereby staff training and other development needs can be discussed.

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. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager demonstrated a good understanding of the principles of the MCA, such as presuming capacity until proven otherwise, and ensuring consent was incorporated into care planning and delivery. We saw appropriate documentation had been submitted to the local authority regarding the DoLS, and a planner ensured review dates were adhered to.

Care records we looked at included Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. These mean if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). The forms we saw were up to date and showed the person who used the service, and their family members, had been involved in the decision making process.

With regard to the premises we saw it was generally in a good state of repair, with ample bathing facilities. We saw a number of sinks in people's rooms required refurbishment and that this was in the registered manager's refurbishment plan. We saw new sinks had been ordered prior to our inspection visit. The building had a large living room, dining area, a separate smaller lounge and an accessible lawned courtyard area. There was a range of signage in place to help people orientate themselves, such as, outside the dining room, 'Come in, we are open – dining hall this way.'

There was a smoking room and on one day of our inspection we noted the door was left open and a smell of cigarette smoke could be detected in the main building. The registered manager committed to ensuring this door was always kept closed.

Through reviewing a range of care files we saw people were supported to access health care services such as GP visits, Speech and Language Therapy (SALT) appointments, dental appointments and chiropody services. Relatives confirmed people had their health care needs met through prompt liaison with external

services. One relative raised a concern about the timeliness of a physiotherapy referral. We followed this up with the registered manager, who we saw had already followed up this request via a GP, prior to our raising it.

Good

# Is the service caring?

## Our findings

We received a range of positive comments from people who used the service about the caring attitudes of staff. One person who used the service said, "The staff are absolutely lovely." Another said, "I can't fault them. They are caring, kind and they remember everyone. I am going to miss them when I go home." One relative told us, "The staff are always very caring and it means when we're not here we have peace of mind." Another said, "I can't say enough about the staff - they're patient and caring. [Relative] can't really have a conversation about anything past the1940s so they sometimes have the same conversations and have to be patient. It's friendly and they try and make little differences where they can."

External professionals we spoke with were consistent in their descriptions of staff conduct, stating, for example, "We get to see a little of their interactions when we visit and they always seem to have a good rapport," and, "There is often banter on the surface but, underneath that, they are always supportive and caring." One relative told us they felt staff on occasion treated everyone in a manner which assumed a friendly banter, and that staff could on occasion be calmer and more respectful.

Throughout our observations of two days we found staff interacted in a friendly manner with people who used the service and the strong consensus of opinion from people who used the service and their relatives was that staff did interact warmly and appropriately. Another relative told us, "The atmosphere is like a home or a family with staff giving 100%".

Representative recent survey responses from people included, "It's a very nice place and I feel very comfortable and at home here – I can be cheeky."

We saw the service had received thank-you cards and letters, the content of which supported the conclusion that staff were caring. Examples included, "Thank you for all the love, kindness and thoughtfulness you gave to [relative]. Also, thank you for the support you gave the family, it was truly amazing," and, "You were all kind and patient with [relative] and cared for [relative] in a dignified manner."

People we spoke with confirmed they were treated with dignity, with one person saying, "Staff are polite – they always knock at my door if they need anything." We saw the service had introduced a Dignity Champion although they did not as yet undertake any formal observations of practices, or feed back to team meetings or the manager directly. The registered manager acknowledged the role of the dignity champion needed to be better defined and utilised to ensure standards of dignity were maintained.

We saw consent was incorporated into care planning and delivery, with staff asking people who used the service if they would like to move before helping them to mobilise, and explaining aspects of care to them. Care files contained consent, for example to share personal medical information with healthcare professionals, and we found staff understanding of the importance of consent was consistent. This demonstrated the service had regard to the specific decisions people needed to consent to.

The majority of relatives we spoke with and external professionals all confirmed they were made to feel

welcome when they visited. One told us, "We get a warm welcome," whilst another said, "It's one of the better services and the atmosphere is a friendly one." This demonstrated the registered manager had helped to ensure that people who used the service felt more at home.

We saw all staff had received end of life care training in October 2016. We spoke with an external healthcare professional who confirmed the registered manager had prepared staff well to deliver end of life care in conjunction with nursing support. They told us, "They have been proactive in that sense, getting plug-in candles, looking into aromatherapy diffusers and getting the right training in place."

People with religious beliefs had access to local clergy, with one person who used the service telling us, "I get frequent visits from my church deacon." During the first day of our inspection there was a church service held in the small lounge and we saw a number of people enjoyed this service. This meant the registered manager had regard for people's religious beliefs and ensured they were able to follow those beliefs in their home.

We saw staff turnover was relatively low and that the service did not use agency workers. People who used the service behaved in a relaxed manner with members of staff and it was evident some people had developed mutually caring relationships with staff over time.

We saw surveys had been returned to the service by relatives, health and social care professionals and residents. They all described the standards of care and the attitude of staff in positive terms.

We found care plans to contain good levels of information regarding people's likes, dislikes and personal histories. When we spoke with people's keyworkers they were able to tell us about people's needs and preferences in detail. One person had not been assigned a keyworker at the time of our inspection – the registered manager explained that this person was new to the service and a keyworker was assigned during our inspection.

We saw people's personal sensitive information was securely stored in line with the confidentiality policy.

Good

# Is the service responsive?

## Our findings

We gathered a range of feedback from people who used the service, relatives and external professionals which demonstrated people's changing healthcare needs were identified and met. One relative we spoke with told us how staff had monitored a person's mobility and ensured their needs were met: "They helped [relative] get their balance back – first with sticks but he was a bit unsteady with those so they tried a roller and he's getting on okay. He was in a bad way but they have got everyone involved and steadied him." External healthcare professionals we spoke with told us, "The person I was supporting was somewhere else and they couldn't settle. Staff here have made sure the right people have been involved," and, "They give us a heads up about any issues and they take advice."

When we reviewed people's care files we saw evidence they had received responsive care from external professionals to meet their changing needs, for example physiotherapy and the Speech and Language Therapy (SALT) Team. We saw daily notes were completed and were sufficiently detailed to ensure care staff and visiting professionals had the right information about people's needs.

Care plans were reviewed monthly and we saw relatives had been involved in updating and reviewing people's care plans. One relative told us, "They listen, they inform us and they give us an opportunity to take part in decisions about my [relative's] care." Relatives confirmed they were regularly involved in people's care reviews and consulted regarding changes to people's needs. Another relative told us, "They always keep me involved and updated." Responses from recent surveys of relatives corroborated these opinions, with relatives stating, "I am always contacted by staff if a decision needs to be made," and, "The GP visited as [relative] was new to the area." We saw similarly positive responses in returned surveys from healthcare professionals. Two examples stated, "The manager and staff have a good awareness of client needs," and, "I have always been kept up to date with any new developments." All responses from external professionals were positive.

Group activities were planned in advance and did have regard to people's preferences. We also saw people's birthdays were celebrated and that when new people moved to the service, they were also introduced by way of a newsletter. Feedback regarding these activities was generally very positive and we saw these activities helped protect people against social isolation. One person who used the service told us, "It was a great party – we're always having parties."

A newsletter was produced by the service to highlight what activities were anticipated over the next few weeks. One relative we spoke with confirmed this was readily available and useful. They said, "Staff always ask us to add things on the newsletter, which I find very informative."

All staff we spoke with, including the registered manager, agreed the service would be better able to provide person-centred activities if they had a dedicated activities co-ordinator in place. We saw the service had recently advertised for the role but had yet to recruit a new member of staff. One staff member told us, "There aren't enough hours in the day to do all the care as well as go around and ask everyone about activities." One relative said, "There are times when I think people could do more," although they did go on

to state, "Often when I visit people are having their hair or nails done."

We saw the registered manager had recently set up the residents/relatives committee and one relative told us, "I feel chuffed I was asked to be in the committee – I can't wait." Whilst the committee had yet to influence improvements to the service, the setting up of the group demonstrated the registered manager valued input from a range of people who used the service and those people close to them. Residents meetings had happened previously and we saw these had led to preferences being met, such as the recurrence of cheese and wine evenings, and a set of armchair exercises. This demonstrated that some activities were in response to people's preferred interests, although more could be done to improve the provision of person-centred activity planning, as acknowledged by the registered manager and staff.

We found that staff had a strong knowledge of people's preferences and were able to incorporate these into daily care, as well as participation in activities. For example, one keyworker described in detail one person's love for dance, seafood, cheesecake and chocolate. We saw this corresponded with information in the person's care file and that they had enjoyed dancing at various parties.

We saw that each care file we reviewed contained a completed 'All about me' document. This described each person's likes, dislikes, history and preferences, with details such as their favourite television show or alcoholic beverage. When we spoke with staff, including people's keyworkers and other staff, they displayed a good knowledge of people's preferences. In order to strengthen this person-centred knowledge we saw the registered manager had put a sign on each person's door with their name and at least one thing that was important to them (for instance, horse racing or football). We found this ensured even staff who were not a person's keyworker would be able to have prior knowledge of someone's preferences. There was also a 'This is my day' document in each care file we viewed, which helped give staff detailed information about specific practical preferences, such as the person's preferred size portion of breakfast and what they would like on a morning to help them get up (in one person's case a cup of tea prior to anything else).

We saw information regarding how to make a complaint was clearly displayed in communal areas and in the service's literature. Relatives we spoke with knew how to make a complaint and who to approach, as per the registered provider's policy. One person who used the service told us, "You can talk to any staff."

One person who used the service had stated in a survey that, "Sometimes meals are close together." We saw the registered manager had responded by reassuring the person that they could have meals at any time. This showed that the responses from surveys were reviewed and acted upon.

Good

# Is the service well-led?

## Our findings

At the time of our inspection, the service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had extensive experience of working in adult social care and displayed a good knowledge of people who used the service as well as the policies and processes of the organisation.

We spoke with a range of people who used the service, their relatives and external professionals, the significant majority of whom were complimentary about the registered manager's leadership of the service and the standards of care they had instilled. One person said, "The manager is lovely," whilst another told us, "[Registered manager] is sometimes quite excitable but you can always go and talk to them." Another person said, "The manager is a very friendly, nice lady," whilst visiting professionals told us, "They are a proud manager and passionate about the place," and, "They are switched on and are in control." One relative and one person who used the service told us they felt the registered manager could on occasion be, "A bit abrupt" in their interactions with people, but we found a strong consensus of opinion that the registered manager set a positive, caring example. We shared this feedback with the registered manager, who confirmed they would continue to be mindful of how they approached individuals to ensure everyone at the service was comfortable.

External professionals we spoke with agreed the registered manager had the right level of competence and background to perform the role, with one stating, "The registered manager is particularly knowledgeable."

We found the registered manager took an interest in the needs and wellbeing of people who used the service and was able to clarify any questions we had about people's needs. Staff we spoke with were positive about the leadership and direction they received, both in terms of their chosen career path and also the ad hoc support they received when needed, for example when experiencing personal difficulties outside of work. One staff member said of the registered manager, "They get involved and make sure there are plenty of staff. You treat people as you would like to be treated." Another member of staff told us, "The support is always there and you can ask anyone anything – it's a good team." We found the registered manager had successfully developed and maintained a culture with a team ethic that was focussed on providing warm, dignified care for people who used the service.

We found they had also developed a culture that was open and where mistakes were used as opportunities to learn, rather than be covered up. For example, the registered manager had introduced a range of 'What would you do?' scenarios into team meetings to ensure staff discussed the kind of errors that can be made with, for example, medication. These sessions were intended to improve practice but also to remind staff to be open about questioning practice. The registered manager told us, "We want people to flag concerns at the smallest errors to avoid anything more serious." We found this attitude had been successfully taken on by the staff we spoke with, who were comfortable raising concerns and confirmed they were supported to do so.

We saw the registered manager had ensured the service had attained the gold standard for managing and

preventing slips, trips and falls via the Pennine Care Foundation Trust Falls Prevention Home Care project, as well as previously completing the 'Six Steps to Success', an NHS programme intended to support care homes to be better prepared to provide end of life care. We also saw the registered manager was working towards achieving accreditation for infection control excellence. This demonstrated the registered manager valued external accreditation schemes to ensure staff were equipped to have the skills to meet people's needs.

The registered manager took a hands-on approach to all aspects of the service, for instance performing regular 'walkarounds' of the service to identify any areas of improvement required.

Quality assurance processes were well planned and completed by the registered and deputy manager. We saw medication audits were completed weekly, whilst a range of other audits took place on a monthly basis, such as audits of the Malnutrition Universal Screening Tool (MUST), care plan audits, pressure care audits, supervision audits, infection control and kitchen audits. We saw these checks were used to ensure all aspects of the service underwent a good degree of scrutiny. We saw errors or inconsistencies were addressed, for example where a risk assessment had not been adequately updated following receipt of new information, this was highlighted and rectified by the registered manager.

The registered manager also undertook unannounced spot checks of the service at a variety of times to ensure staff maintained good levels of care and that people who used the service were safe. We saw recent visits had occurred at 1.30pm on a weekend, 7.30pm and 4:30am, which meant staff were subject to spot checks at any time.

The registered manager described a good level of support from the area manager, who we spoke with. They visited the service regularly and undertook their own walkaround of the service. The registered manager was required to provide the area manager with a monthly overview of audits and we found this added additional levels of scrutiny to service provision. Likewise when we spoke with staff they described the level of support they received from the registered manager in positive terms, and agreed the audits and unannounced visits were a positive thing. This demonstrated the registered manager assessed and monitored all aspects of the service to ensure errors were identified and improvements could be made.

During the inspection we asked for a variety of care and policy documentation to be made accessible to us. These were promptly provided, accurate and up to date. We found the service to be well organised and appropriate notifications had been made to CQC.

We spoke with a commissioning professional who confirmed the registered manager was, "Proactive" in making sure they complied with local authority guidance. We found the registered manager had built and maintained strong working relationships with commissioning and other sector professionals.

We found the registered manager had ensured the service remained part of the wider community, for example through inviting entertainers and other visitors to the service, arranging Halloween, fancy dress and Bonfire night parties and hosting regular services by a local church.