Dipton Care Home Limited

Dipton Manor Care Home

Inspection report

Front Street
Dipton
Stanley
County Durham
DH9 9BP

Date of inspection visit:
24 October 2018
31 October 2018

Date of publication:
29 November 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

The inspection took place on 24 and 31 October 2018 and was unannounced.

We last inspected the service in February 2018 and found the provider had breached two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. These related to the provider not ensuring the principles of the Mental Capacity Act were being followed, and systems and processes used to assess, monitor and improve the safety of the services provided had not identified the concerns we found. We asked the provider to complete an action plan to show what they would do to improve the service.

Dipton Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Dipton Manor can accommodate up to 70 people over four separate units. The Derwent and Lintsford units provide support for people requiring residential care. The Bradley unit provides support for people living with dementia and the Pontop unit provides support for people requiring nursing care. At the time of our inspection 58 people were using the service, including 16 who were receiving nursing care. The home was set in its own grounds with an enclosed garden.

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.

The provider had a plan in place to ensure risk assessments and care plans were more personalised which was in the process of being implemented. We found some care records had been re-written to be more personalised. However, some still did contain task orientated information and on occasions did not contain appropriate information. We spoke with staff and found they were supporting people in a personalised manner.

We found some shortfalls in terms of record keeping. Records to provide information for staff in administrating topical medicines and 'as required' medicines were not in place for some people. Some food and fluid charts were not always completed and reviewed.

The provider's quality assurance system had not identified the shortfalls we found in record keeping. This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.
We found the provider has strengthened Mental Capacity Act 2005 (MCA) and Deprivation of Liberty

safeguards (DoLS) training for staff. We found staff had a clearer understanding of the principles of the Act. MCA assessments and best interest records were in place for some people. The registered manager advised all MCA assessments and best interest records were in place before the end of the inspection process.

Recruitment processes were in place with all necessary checks completed before staff commenced employment. Staff received an induction on commencement of their employment. The provider used a dependency tool to ensure staff levels met the needs of the people living in Dipton Manor.

Staff were aware of safeguarding processes and knew how to raise concerns if they felt people were at risk of abuse or poor practice. Where lessons could be learnt from safeguarding concerns these were used to improve the service. Accidents and incidents were recorded and monitored as part of the provider's audit process.

Health and safety checks had been completed such as gas and electrical safety checks. Equipment used to support people had been checked and/or serviced.

Systems and processes were in place to ensure medicines were available for people. Medicines were managed by trained staff whose competency to administer medicines was checked regularly.

Staff received regular supervision and an annual appraisal. Opportunities were available for staff to discuss performance and development. Staff essential training was up to date.

People's nutritional needs were assessed and we observed people enjoying a varied diet, with choices offered and alternatives available. Staff supported people with eating and drinking in a safe, dignified and respectful manner. People were supported to maintain good health and had access to healthcare professionals when necessary and were supported with health and well-being appointments.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

People and relatives felt the service was caring. Staff provided support in a respectful manner ensuring people's privacy and dignity was promoted. Where possible people were supported to be as independent as possible.

The provider ensured people were supported to attend a broad range of activities and entertainment within the setting.

The provider had a complaints process in place which was accessible to people and relatives.

Staff were positive about the registered manager. They confirmed they felt supported and could raise concerns. We observed the registered manager was visible in the service and found people interacted with them in an open manner. People and relatives felt the management approach in the home was positive.

The premises were well suited to people's needs, with ample dining and communal spaces. Bedrooms were personalised to people's individual taste. Bathrooms were designed to incorporate needs of the people living at the home. The garden area was accessible to people.

The provider worked closely with outside agencies and other stakeholders such as commissioners and social workers

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. Charts for transdermal and topical medicines were not available for staff guidance.

Risk assessments were not in place for some people to provide support and guidance for staff.

The provider ensured accidents, incidents and safeguarding issues were investigated and addressed. Staff were recruited following relevant checks.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and an annual appraisal. Training needs were monitored, with courses arranged when necessary to keep staff up to date.

People received a varied healthy diet. Staff monitored people's nutritional needs on a regular basis.

Staff understood the principles of the Mental Capacity Act 2005. People were supported in the least restrictive way possible.

Is the service caring?

Good

The service was caring.

Staff demonstrated positive relationships with the people they supported.

People felt the staff supported them with dignity and respect. Relatives felt the service demonstrated a caring approach to their family members.

The provider had information regarding advocacy which was available to people and their relatives.

Is the service responsive?

Good

The service was responsive.

Care plans were in place which contained people's like dislikes and preferences. Care plans were being reviewed regularly.

The provider had a policy and procedure in place to manage complaints. People and relatives knew how to complain.

The provide ensured staff had training in end of life care to support people when necessary. Relatives had complemented the service on their end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance process was not effective and did not highlight the record keeping concerns found at this inspection.

The registered manager was responsive to our findings and addressed some of the shortfalls immediately.

People, relatives, health care professionals and staff felt the registered manager was supportive and approachable.

The registered manager submitted statutory notifications in line with registration requirements.

Dipton Manor Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 24 and 31 October 2018, the first day of the inspection was unannounced. This meant the provider did not know we were coming. The first day of the inspection was carried out by one adult social care inspector, one specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The second day of the inspection was carried out by one adult social care inspector.

Before the inspection we reviewed other information we held about the service and the provider. This included statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We also contacted the local authority commissioners for the service, the local authority safeguarding team the clinical commissioning group (CCG) and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with ten people who lived at Dipton Manor. We spoke with the registered manager, deputy manager, the administrator, one nurse, the activity coordinator, three coordinators, three care workers and one health care professional. We also spoke with six relatives of people who used the service and one visitor.
We used a short observational framework inspection (SOFI) to capture the experiences of people who use services who may not be able to express this for themselves.

We looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of six people, medicine administration records of eight people, recruitment records of four staff, training records and records in relation to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found the provider had not identified that some people's risk assessments did not clearly demonstrate how risks had been identified or what was being done to reduce the risk.

At this inspection we found risks were assessed to ensure people were safe and where possible actions were identified for staff to take to reduce risks occurring. For example, from the records we viewed we saw risks such as moving and assisting, choking, falls and skin integrity had been considered.

However, on the nursing unit we found two people with health needs who did not have appropriate risk assessments in place. One person who was diagnosed with diabetes which was managed via medication did not have a risk assessment in place for staff support and guidance. Another person who has a Percutaneous Endoscopic Gastrostomy (PEG) did not have a risk assessment in place. A PEG is a tube which is passed into a person's stomach to provide a means of providing nutrition when oral intake is not adequate or possible. We discussed our concerns with the registered manager who advised risk assessments would be completed to accompany the care plans. On the second day of the inspection risk assessments were in place.

We found two people who were assessed as being at risk of developing pressure areas. Both required the use of a pressure relieving mattress, however records did not contain the required setting for the mattress. We asked the nurse on duty to check the settings for people. On the second day of the inspection we found mattress settings were also recorded on the mattress check list to enable a more robust check.

Were people required positional changes to maintain their skin integrity or to reduce the risk of further pressure damage re-positioning records were in place. We found inconsistencies in how the forms were completed. Whilst some records contained a good level of detail we found did some did not detail the specific position the person had been placed in. We checked records on the second day of the inspection and found this had been addressed.

We looked at the arrangements for the safe management of medicines.

We reviewed eight people's medicine records. There were no protocols in place for 'when required' medicines (called PRN medicines) for two people who required pain relief. One person was prescribed medicine that could be used for agitation and anxiety. There was no PRN protocol in place to assist staff in their decision making about when to administer the medicine.

People who had medicine administered via a transdermal patch (a transdermal patch contains medicine which is applied to the skin) did not have a patch administration site record in their medicine records. Patch administration records provide details of where the patch has been placed to allow rotation on other parts of the body so not to cause skin irritation.

One person required their medicines to be administered covertly. The covert administration of medicines

occurs when a medicine is administered in a disguised format without the knowledge or the consent of the person, for example, mixed with food or drink. A letter from the GP from October 2017 authorisedthis method of administration. However, the medicines to be administered covertly were not listed and no records were available to evidence a best interest meeting with the GP, staff and the pharmacist had taken place.

Where creams and ointments were prescribed a topical medicines administration record (TMAR) should be available to ensure staff apply the topical medicine in the correct areas. We found people did not have TMARs in place. This meant we could not be sure the medicine had been applied to the correct area.

We discussed our findings regarding management of medicines with the registered manager and deputy manager who advised this would be addressed as a matter of urgency. On the second day of the inspection we found PRN protocols were in place, TMARs and transdermal patch application records had been introduced. Best interest documents were in place regarding the administration of covert medicines.

The provider's quality assurance system had not picked up the issues we found in relation to records.

This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with told us the service was safe. One person told us, "I don't lock my door and every time I press my buzzer they come straightaway." Another person told us, "I never want to leave, I was frightened at home, but here it's safe, secure and couldn't be better." One relative said, "My [relative] wouldn't be in her if it wasn't safe, they are doing a good job and as far as I can see they are certainly exceeding expectations."

We checked the provider's recruitment process. Staff files contained application forms, checks in employment gaps, interview documents and identity checks. New employees had also received clearance from the Disclosure and Barring Service (DBS) that they were able to work with vulnerable adults and that they could do so without restriction. The provider also employed nurses as clinical support for the organisation. We found the provider carried out regular checks on nurse's personal identification numbers (PIN). PIN is the number issued to nurses to prove they are registered with the Nursing and Midwifery Council and can practice as a nurse.

The registered manager kept a record of all accidents, incidents and safeguarding concerns. Where lessons had been learnt from any incident these had been discussed with staff during team meetings or supervisions.

Staff had received training in safeguarding which was refreshed on a regular basis. Staff were confident the registered manager would act on any concerns. Staff were clear about what constituted abuse and how they could recognise if someone was being abused.

The registered manager completed a dependency review of people's needs to ensure the staffing levels in the home were at a safe level. We found staff were visible in the home and buzzers were answered in a timely manner. One person told us, "There always seems to be staff around when I need them." Another person said, "They are busy but I never have to wait - they are just angels."

The provider ensured health and safety checks were carried out. For example, gas safety checks and portable appliance checks (PAT). Environmental risks were also documented such as slips, trips and falls

along with infection control risks. These were readily available for staff to access.

The home was clean and tidy with no odours. Ancillary staff carried out daily cleaning routines on each unit. Arrangements were in place for deep cleaning, redecoration and refurbishment of the home.

Good

Is the service effective?

Our findings

At the previous inspection we found the provider had not ensured the principles of the Mental Capacity Act 2005 were being followed. People who were being deprived of their liberty did not always have decision specific best interest meetings recorded in their care records. Staff did not have a clear understanding of how to apply the Act.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We found the provider had implemented new MCA assessment documents along with best interest records and staff were working through care records to ensure the correct documents were in place. We saw the best interest decision records were thorough and decision specific. The quality assurance tool for care plan audits now included a specific area around MCA and best interest decisions to ensure compliance.

We found one person who was unable to sign their consent forms did not have any best interest documents in place. The registered manager advised that this would be addressed. Where people were being supported by Lasting Powers of Attorney (LPA) a copy of the LPA was on file and the legally authorised representative had signed the consent forms.

The registered manager confirmed to us that all MCA assessments and best interest records were in place before the end of the inspection process.

At this inspection we found staff had a better understanding of the Act. The provider had implemented additional training for staff. Coordinators along with nursing staff had received MCA training at level 3. Care staff had completed face to face MCA and DoLS training at level 2.

The registered manager kept a record of all DoLS applications and authorisations to ensure any further application could be made in a timely manner.

People's needs were assessed before they moved into the home to make sure staff could care for the person and had the equipment to ensure people's safety and comfort

People and relatives felt the service was effective in meeting their or their family member's needs. One person told us, "They are very well trained, they look after my needs. Nothing and I repeat, nothing is too

much trouble." Another said, "They instil confidence in me." One relative told us, "They are so very well trained. They seem to know all [name] likes and doesn't like."

One health care professional told us, "They seem very knowledgeable, nursing staff support, it's integrated care, care staff worked between floors and they are very adaptable."

Staff completed an induction to the service and received training appropriate to their role prior to commencing work unsupervised. The deputy manager had developed a matrix to monitor staff training. Staff completed a range of training to cover the needs of the people using the service.

Staff told us they felt supported and received regular supervision and an annual appraisal. We saw supervisions were detailed and contained discussions about personal development. One staff member told us, "I have it [supervision] regularly, but don't have to wait if I have a problem I can go to [coordinator]." Another said, "We are supported, we support each other. We are like a family."

People were supported with their nutritional needs and told us they enjoyed their food. One person told us, "They give me artic role as they know it's my favourite." A second person said, "The food is great, I like sweet things and they make all their own cakes and biscuits which are lovely." A third told us, "The food is great, the fish and chips are to die for, I have not seen a bad meal yet." Where necessary speech and language therapist (SALT) guidance was included in the person's support plan for staff to follow. Staff we spoke with understood the need for food to be of a specific consistency and how to prepare thickened fluids. Catering staff had details of people's dietary needs, these were updated when necessary.

Systems were in place to ensure people who were at risk of under nutrition were supported to maintain their nutritional needs. We found people were supported to access speech and language therapists (SALT) and dieticians. We noted some food charts did not specifically record the amount of food eaten, and fluids were not always totalled. This was discussed with the registered manager who advised staff had received the local foundation trust's 'Focus on Under-nutrition (FOU)' guidance and were aware of the need to complete these fully. FOU provides training and resources to assist care homes to manage the risk of under nutrition through using real food. Records had improved on the second day of the inspection

People were supported to access external health care professionals to maintain and promote their health. Care plans contained information on the involvement of professionals such as GPs, tissue viability nurses and community matrons.

The premises were suited to people's needs, with dining and communal spaces for people to socialise. The Bradley unit had been updated to be more dementia friendly. Tactile objects were in place for people to touch and feel as they orientated around the unit.

Bedrooms were personalised to people's individual taste, containing personal effects and pieces of furniture making them homely and familiar. Bathrooms were designed to incorporate needs of the people living at the home. The large garden area was accessible to people and relatives with stunning views across the countryside. One person told us, "I have the best room, just look at my view." Another person told us, "I just love to sit in here [in the lounge] you can see for miles."

Good

Is the service caring?

Our findings

We observed many caring and respectful interactions between staff and the people living at Dipton Manor. Staff did not rush people to make decisions and were led by what the person wanted to do. People appeared comfortable and relaxed in the presence of staff. We saw staff also had a good relationship with those who visited the home, staff were open and welcoming offering tea or a coffee.

All the staff that we spoke with showed genuine interest in people's wellbeing. We observed staff knocked on people's doors and waited to be invited in. Staff spoke with people and their relatives in a respectful manner, we observed humour was used and people enjoyed a laugh and a joke with staff. It was obvious from discussion that all staff knew people very well, including their likes, dislikes and preferences and had used this knowledge to form positive relationships.

People and their relative told us how caring staff were. One person told us, "They are kind and caring, I feel looked after and if I need anything they are there." Another told us, "I've never seen such care in my life. I've seen my care plan and everyone does their job well." One relative told us, "They constantly monitor [Name] and I cannot speak highly enough of the care here." Another relative who asked to speak with us said, "They are absolute angels, just superb I have faith and confidence in all of them." They went on to explain that the care and dedication was 100% and given with tenderness and humour in abundance.

The service ensured people's spiritual and cultural needs were met. We spoke with one relative who told us, "They cater for spiritual needs. We renew our wedding vows every year. They organise for us to have a special day. The lay preacher comes it is fabulous." We spent time with a verger who was a regular visitor in the home. They told us, "I visit weekly, I pray with people, it is such a pleasure to come in."

Care records described how staff were to respect people's privacy and dignity. One person told us, "They keep my dignity and lock my door when I'm having a shower but encourage me to do what I can." Another said, "I can go and get up when I want to, I like to be up at 7am but that is my choice."

During the inspection we saw staff knocked on people's doors before being invited in. Staff ensured doors were closed when they were supporting people with personal care. People were asked if they wished to go to their room when visitors arrived for privacy. One staff member told us, "I treat people how I would want to be treated, it is important to do that." Another told us, "I close curtains, doors always making sure they have privacy."

Staff gave us examples of how they promoted people's independence. People were supported and encouraged to get up unaided, when appropriate, and to use mobility aids. We saw staff members cut up food for people but then encouraged them to eat independently.

People's preferences and choices were recorded in their care records. For example, interests and hobbies and personal care preferences. Communication plans were in place and were appropriate for the person. We saw specific information for staff to follow in relation to how they engaged with people. This meant staff

recognised people could still be engaged in decision making and interaction.

We joined people in the dining rooms at lunch time. Tables were set with condiments and cutlery. People were asked if they wanted to wear protection for their clothes before being served their meals. We observed staff demonstrating respect for people by asking what they preferred for lunch, offering choices and alternatives. Staff supported people to eat and drink in a safe manner and to be as independent as possible. Meals were not rushed, people were given time to eat their meal at a pace of their choosing.

Where people were supported to eat we saw staff sitting with them at eye level. People were given food only when they were ready for the next mouthful. Drinks were offered regularly. When the meal was finished, staff made sure people were comfortable before leaving them in their chosen area.

We saw that records were kept securely and only accessible by staff. This ensured the confidentiality of people's personal information.

Information on advocacy services was made available to people who used the service. Advocates help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The registered manager advised that contact would be made with the person's social worker if necessary.

Good

Is the service responsive?

Our findings

At our previous inspection we found the provider's quality assurance process had not identified that care plans were not always personalised and had not been reviewed regularly.

At this inspection we found the provider had worked with the local authority to develop care plans and were implementing a more personalised approach to care plans. Some care plans had been re-written and contained details of how to support the person on a more individual basis. For example, one person's mobility plan stated, "I use a Zimmer frame and need reminding to take it with me, I have a little basket attached so I can take my handbag with me." Another person's diabetes plan set out how they may present if their blood sugar levels were high or low and what staff should do.

We found some plans had not yet been fully updated and these still contained more task orientated information. We discussed this with the registered manager who advised that this work is ongoing. Further visits by the local authority were due to monitor the improvements.

Two people who had skin integrity needs had wound care plans in place. We saw these were not detailed in terms of the nature of the wound or the progress made. We discussed this with the clinical lead who reviewed the care plans and updated records to include a measurement record so staff could record the actual size and presentation of the wound. We found the tissue viability nurse had assessed people's skin condition and provided specialist support on what was needed in terms of care and support which the staff were following.

We saw the provider used either "About me" or "This is me" documents which contained detailed personal histories so staff had information about the person and what their likes, dislikes and preferences were. All staff we spoke with told us how they ensured people were treated as individuals and that people's care was delivered in a personalised way. One staff member told us, "[Name] likes to get up at a certain time, that is in there." One care coordinator told us, "We have been working on care plans to make them more detailed. They are better now."

We asked people and relatives if they felt the care was personalised to their needs. One person told us, "I am treated so well and they do everything the way I want, now that's what it's all about." One relative told us, "Everything about Dipton Manor is personalised."

We found all care plans had been reviewed regularly and were updated following visits from health and social care professionals to ensure staff had the most current information. During the inspection we observed staff updating care records following a visit from the community matron.

Where appropriate people had end of life care plans in place. These gave staff details of people's wishes and how they wished to be supported. We found staff had received training in supporting people at the end of their lives. Compliment cards demonstrated families had been grateful for the care and support provided to their loved ones who had passed away.

One relative who had experienced the end of life care provided by Dipton Manor advised, "The nursing and caring team came across as being very professional and organised with good leadership. Our view is that our father had excellent care whilst in the nursing home. There were high levels of attention to his comfort, personal hygiene and nursing care. Particularly impressive was the personal attention he received by staff going above and beyond their duties to ensure he was comfortable. The home manager clearly leads by example and created a friendly and caring culture in the home. This was mirrored by the lead nursing staff on the floor."

The service was dedicated to protecting people from the risks of social isolation and recognised the importance of social contact, friendships and family contact. The provider employed two activity coordinators to support people with recreation and leisure, with a third soon to commence employment. We spoke to one activity coordinator who was on duty. We found the co-ordinators took time to get to know people and spoke with family members to find out more about their lives. We saw a range of activities were available in the home such as bingo, singing, card games, artwork and church involvement. Flyers were posted in prominent areas in the home for people and relatives to see what was up and coming.

During the recent royal wedding celebrations, a wedding dress had been on show for people to look at and talk about. People were busy knitting poppies for Remembrance Sunday. We saw "the ladies who lunch group" had been out to the local garden centre for lunch. One person told us, "We have had the best time, what a lovely meal." One relative told us, "There are about 30 people who go to the coffee mornings, that is phenomenal, everything is light, social and a sense of togetherness prevails." The activity coordinator told us, "The men are going to a pub lunch on Saturday." They told us that a pantomime had been booked and a Chinese food taster night had been organised. The activity coordinator told us, "To be honest I consider this [activity organising] to be an enrichment of life for residents and that is everyone's job, not just mine."

We looked at how complaints were managed in the service. The provider had a policy and procedure in place which provided clear information for people who used the service. We found where complaints had been made the registered manager/provider had responded. Lessons learnt from complaints were discussed at staff supervision and at team meetings.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection we found the provider's quality assurance process used to assess, monitor and improve the safety of the services provided had not identified the concerns we had found in relation to compliance with the MCA, lack of personalised care plans and reviews.

During this inspection we found some improvements had been made to the quality assurance process and new documentation had been introduced in terms of MCA assessments and best interest meetings records. Care plan audit documents had also been updated. Staff training was now more in-depth in terms of MCA and DoLS with staff having a clearer understanding.

However, we found the systems for auditing medicines and record keeping were not effective and had not identified the issues we found.

This was a continuous breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We acknowledged the registered manager and deputy manager recognised the importance of addressing the concerns we found and addressed some areas before the end of the inspection process.

People and family members provided feedback on the quality of the service. One person told us, "The care here is fantastic." Another said, "I can't think of anything that they wouldn't try to do for you. I hope I never have to leave." One relative told us, "Everything is good, to go home with peace of mind is a massive weight of my mind." Another said, "The way this home is managed feeds from the top." Compliment cards gave positive views of the quality of the home. Comments included, "I would highly recommend this home."

Actions from quality audits were monitored by the registered manager and used by the area manager as part of their quality visits. Actioned were signed off when completed or carried over if more time was needed to address issues. We found the registered manager held head of department meetings every week. The registered manager told us, "This ensures information is passed on, we discuss the audit results as well."

Financial audits were completed by the providers financial department on a weekly basis.

People and relatives told us they felt the management in the home was open and approachable. On the day of the inspection we found the registered manager and deputy manager were easily accessible to people, relatives and staff. Everyone we spoke with knew the registered manager. One person told us, "The manager has a good reliable team working with her, having a calming effect on everyone." Another said, "Oh she is lovely, they all are really, but she is a bit special." One relative told us, "[Registered manager] is unbelievable, she is great, I cannot speak highly enough of them."

The registered manager was supportive of the staff team and took their responsibilities in supporting staff seriously. Processes were in place to ensure staff were supervised, training organised and rotas developed to

meet the needs of the service.

Regular team meetings were held. These were recorded and made available for those who could not attend so important information was disseminated to all staff. The minutes of meetings demonstrated these were open and encouraged discussion with the staff team. Ideas and suggestions were acknowledged and discussed during meetings.

Staff we spoke with felt supported by the management team. Staff were regularly consulted and kept up to date with information about the service. One staff member told us, "They [registered manager and deputy manager] do listen, you can go to them at any time." Another told us, "Morale is much better now, [registered manager] is approachable and we are kept up to speed."

The service worked in partnership with many agencies, including the local authority, safeguarding teams and multidisciplinary teams, to ensure people received joined up care and support. We saw close links with the local authority provider improvement officers.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems and processes were operated effectively to assess, monitor and improve the quality of the services provided. Regulation 17 (2)(a)