Old Raven Limited

Old Raven House

Inspection report

London Road
Hook
Hampshire
RG27 9EF
Tel: 01256 762880
Website: www.oldravenhouse.co.uk

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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

Overall summary

The inspection took place on 24 and 26 March 2015.

Old Raven House is a care home in Hook that provides accommodation, care and support for up to 36 older people. At the time of the inspection 36 people were using the service. Some of the people using the service are living with dementia.

Old Raven House has a registered manager in post. 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 and associated Regulations about how the service is run.

At the last inspection in July 2014 we asked the provider to take action to make improvements regarding the care and welfare of people who use the service. We also asked them to make improvements in respect of management

Summary of findings

of medicines, supporting workers and record keeping. The provider wrote to us and told us what they would do to improve the above areas and we found that improvements had been made.

People using the service told us that they felt safe. Safeguarding training was delivered annually and care staff were able to identify and recognise signs of abuse. Procedures were in place identifying how people could raise concerns and staff were aware of these.

Care staff were knowledgeable about the requirements of The Mental Capacity Act 2005 (MCA) and documentation showed people's decisions to receive care had been appropriately assessed, respected and documented. Care staff were able to demonstrate a working knowledge of the MCA and the Deprivation of Liberty Safeguards (DoLS). They were able to evidence that they could identify when someone was being deprived of their liberty.

When risks were identified people were supported to remain safe. Care staff were able to recognise risk and change their care accordingly to meet any additional needs.

Staff recruitment procedures were in place so that people were protected from the employment of unsuitable staff. Induction training was mandatory to assess care staff were suitable for their roles.

Care staff responsible for supporting people with their medicines had received additional training to ensure people's medicines were being administered, stored and disposed of correctly. However we found that for one person their medicine had not been given as they had wanted.

People were supported to eat and drink enough to maintain a balanced diet. When identified, people at risk of malnutrition and dehydration were properly assessed to ensure their needs were met. People told us the food was of a good standard and in more than sufficient quantities.

When people's additional health care needs were identified the registered manager engaged with other health and social care agencies and professionals to maintain people's safety and welfare.

People told us that their care was provided to a good standard. Care staff were able to demonstrate they had taken time to know the people they supported. People were encouraged and supported by care staff to make choices about their care on a daily basis.

People told us and we could see that all staff treated people with respect and ensured their dignity was respected at all times.

Care plans were personalised to each individual and contained detailed information to assist care staff to provide care in a manner that respected that person's individual needs and wishes. Relatives were involved at the care planning stage and during regular reviews.

People knew how to complain and were happy to provide feedback if this was required. Procedures were in place to manage and respond to complaints in an effective way.

Residents, relatives and care staff were actively encouraged to provide feedback on the quality of the service provided by the use of quality assurance questionnaires and regular meetings. Care staff felt supported by the registered manager as a result.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe

The provider had a robust recruitment and training process to ensure people were cared for by staff who knew how to recognise signs of abuse and how to deal with concerns appropriately.

Contingency plans were in place to cover unforeseen events such as fire or flood.

Care staff involved in dispensing medicines were trained and subject to continual review to enable them to conduct this role safely

Is the service effective?
The service was effective.

The staff in the home knew the people they were supporting and the care they needed. Care staff understood the principles of the Mental Capacity Act 2005 and were able to show an understanding of the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were supported by care staff who encouraged people to eat and drink. A nutritionist visited to ensure people's needs were being met.

Care staff supported people to seek healthcare advice and support wherever required.

Is the service caring?
The service was caring.

People told us that they were well cared for and care staff were motivated to develop positive relationships with people showing an interest in their personal histories.

Relatives were involved with the provider in planning and documenting their care allowing them to express their families needs and preferences.

Care was given in a way that was respectful of people and their right to privacy whilst maintaining people's safety.

Is the service responsive?
The service was responsive

People's needs had been thoroughly and appropriately assessed. Risk assessments were reviewed on a regular basis with additional reviews when needs identified.

People were encouraged to make choices about their care which included where and how they wished to spend their time in the home.

Is the service well-led?
The service was well led.

The registered manager was a recognisable face to people living and visiting the home and able to provide advice and support where needed.

Care staff were aware of their role and felt supported by the registered manager who operated an 'open door' policy.

Summary of findings

The registered manager regularly checked the quality of the service provided using questionnaires and family meetings. The registered manager made sure people knew how and where to complain if they were unhappy or concerned.

Old Raven House

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 function. This inspection checked whether the provider was 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 unannounced inspection was carried out on the 23 and 25 March 2015 by two inspectors 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 care service.

Before the inspection we examined previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law.

We spoke with eight people who lived at the home, five visiting relatives, the provider, deputy manager, two care staff and the chef.

Throughout the day we observed care and support being delivered in people's rooms and the communal areas of the home. We looked at six people's care plans, seven care staff and one maintenance staff recruitment files, staff supervision and training records, a duty roster for care staff for a two week period before the inspection, 20 medicine records, policy and procedures and quality assurance questionnaires results.

We also spoke with an additional two care staff and two relatives of people using the service.

The previous inspection was carried out on the 31 July 2014 and breaches of regulations were found.

Is the service safe?

Our findings

People told us they felt safe living at Old Raven House. They were comfortable and relaxed in the care staff and registered manager's presence. One person told us they would, "definitely recommend" living at Old Raven House. A relative told us, "I would not want him to go anywhere else".

Medicine errors were picked up by the registered manager and addressed. For example, it had been identified that one person had not received their medicine as prescribed. One person told us that they had not been given their medicine on two consecutive occasions in the week before the inspection. This person's Medicine Administration Record (MAR) confirmed this. The deputy manager told us that the time of giving the person's medicine had been brought forward from the evening to late afternoon. However, this had not been acknowledged by the member of care staff who completed the late afternoon medication round. This was going to be addressed by the deputy manager with the member of care staff involved.

Arrangements were in place for the safe storage and management of medicines. The home did not have any controlled drugs (CD) being provided at the location. CD are medicines which may be misused and there are specific ways in which they must be stored and recorded.

Medication audits were completed monthly and when areas for improvement were identified care staff involved were asked to complete an additional medication competency. This was to evidence their suitability to continue in the role. These occurred every three months as a matter of course to ensure skills and knowledge were maintained.

Care plans, where required, included medication risk assessments detailing what medicine needed to be taken, when and the best way to administer. One risk assessment included detailed information such as giving the medication in a, 'spoonful of yoghurt or jam or chocolate" which was the preferred choice of the person receiving this. There had been communication with a GP when someone had repeatedly refused medication. The GP had completed a covert medication form which confirmed that the medication was suitable for administration and was listed in the person's care plan. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. Crushing medicines may alter the way they work and make them ineffective. A need had been identified for this method of giving medicine and appropriate discussions with the GP to ensure that the best interests of the person receiving the covert medicine were promoted.

People were protected as the provider had a robust recruitment system. The registered manager was able to evidence that the newest care staff had all the required documentation. These staff files included previous employment references and pre-employment checks. All new staff had a Disclosure and Barring Service (DBS) check returned before they worked in the home. A DBS check enables employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with vulnerable people.

The registered manager and care staff had a good understanding of safeguarding and what actions and behaviours would constitute abuse. Notifications showed that the registered manager had identified and reported a safeguarding incident between people using the service.

Care staff were knowledgeable about their responsibilities when reporting safeguarding concerns. They received training in safeguarding vulnerable adults and were required to repeat this on an annual basis. Records showed that four out of 22 care staff had not received safeguarding training

in 2014. It was confirmed that training had been booked and all staff would have completed refresher training by the end of May 2015. The registered manager told us disciplinary procedures would be used if care staff failed to attend essential training.

The provider's safeguarding vulnerable adult's policy provided guidance for all staff on how to raise a safeguarding alert. It contained detailed information about where to report concerns including, Social Services, the Care Quality Commission (CQC) and the Police, if necessary.

When a potential risk was identified care staff responded appropriately. For example, one care plan had a detailed support plan in place to manage the risk of the person 'bumping into things'. The care plan detailed how the person wanted to be able to remain independent and continue walking unaided despite suffering previous falls. This support plan was reviewed for a number of months

Is the service safe?

until it was identified that the person needed additional support. Their care plan and risk assessment had then been updated to reflect their change in care needs. As a result this person was moved to a downstairs room and had no further falls.

There were robust contingency plans in place in the event of an untoward event such as a fire or flood to minimise the risk of harm to people. In the event of evacuation people using the service would be moved, temporarily, to a hotel nearby. These plans were detailed and ensured that the potential risk of harm to people was minimised whilst maintaining their continuity of care. Evacuation processes were also practised with all staff on a regular basis at team meetings to ensure that in the event of an emergency all staff would be clear on their roles and responsibilities.

There were sufficient care staff deployed to meet people's needs. The registered manager told us that they determined overall staffing numbers dependant on people's needs and this was subject to continual review. This included taking into account whether people's health had deteriorated and they required one to one support. Care staff responded quickly to call bells. People we spoke with raised no concerns regarding having to wait for assistance when it had been requested. Call bell audits for the previous two weeks showed that 100% of call activations had been responded to within 5 minutes which assisted people in feeling safe in their environment.

We observed safe medicine administration practice. Medicines that were no longer required or were out of date were appropriately disposed of on a monthly basis with a local contactor and documented accordingly.

Is the service effective?

Our findings

People were positive about the care staff ability to meet their care needs. One relative told us that they were "very happy with her care". A quality questionnaire stated, "everything is lovely", and, "all the staff are wonderful, especially X, I never need to complain".

Relatives told us they felt staff were knowledgeable about the care they provided and said their family members needs were met to a good standard.

All staff received an effective induction into their role at Old Raven House. Each care worker had undertaken training such as manual handling, health and safety and safeguarding vulnerable adults to enable them to conduct their role. Care staff were also encouraged by the registered manager to request additional training where they identified an interest. One member of care staff told us they had wanted to undertake training in end of life care and this had been provided recently.

The registered manager had identified suitable care staff who had been nominated to take on additional responsibility for different aspects of care. It was expected that this person would challenge poor practice, act as a role model and educate and inform the care staff. One member of staff we spoke with had responsibility for tissue viability. Tissue viability is about the maintenance of skin integrity, also the management of people with acute and chronic wounds. They told us that they had attended additional training in order to undertake this role and had built up very good links with the local GP surgery as a result. There was also a dementia and a falls champion.

Care staff had regular supervision and appraisals with the registered manager and senior staff.

Supervision and appraisal are processes which offer support, assurances and learning to help staff development. The provider's policy on staff supervision detailed the importance that these were planned, protected and uninterrupted. Team leaders were nominated as supervisors and provided with additional training in supervision. They then took responsibility for conducting regular reviews with their care staff. Care staff told us they had regular meetings and they would occur fortnightly to three weekly. These were seen as constructive meetings which were welcomed and considered useful by care staff.

People's consent was sought before the delivery of care or support. People told us that care staff always sought their consent before giving care and were very polite. Observations throughout the inspection confirmed that care staff asked permission before assisting people. Care records showed that care staff were routinely asking people if they were happy for them to deliver care and documenting their response.

People's views and decisions were respected. Some people were unable to express their views or make decisions about their care and treatment. The Mental Capacity Act 2005 (MCA) contains five key principles that must be followed when assessing people's capacity to make decisions. Staff were knowledgeable about these requirements and records showed people's capacity had been properly assessed and documented. Staff were able to illustrate the principles of the MCA and described the times when a best interest decision may be appropriate. For example, in relation to the MCA one member explained that people had to be entitled to make their own choices even if that wouldn't be what they would have thought would have been best for them. They could not make people's choices for them if they had the capacity to decide what to do.

Staff responded effectively to ensure people's freedom was not unlawfully restricted without authorisation. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. There were four people subject to DoLS at the time of our inspection. Staff were knowledgeable about what would constitute a DoLS, for placing someone in a wheelchair in front of a table or strapping someone into a wheelchair.. Records showed care staff regularly reviewed people's DoLS and considered the least restrictive option. The registered manager told us that person had been exhibiting sexual behaviour and to protect other people and themselves the decision was made to place the persons belt on backwards. This allowed the person to maintain their independence and move unrestricted within the home without posing a threat others.

People told us they enjoyed the food and this was served in sufficient quantities. Positive comments from a recent questionnaire included, "the food is lovely, always enjoy

Is the service effective?

salads, chef does me a salad". A relative said, "the meals are very good" and that their mother had told them, "the food here is absolutely marvellous". We observed people enjoying their food at meal times and being given choice. Care staff showed people what was available to assist them in their decision making. Care staff were knowledgeable who required a pureed, soft and normal diet. The kitchen was situated on the ground floor and easily accessible to people. This encouraged a relationship between people and the chef who was able to identify people's dietary needs and requirements as well as people's personal likes and dislikes. Snacks and cold drinks were readily available and actively encouraged to ensure people remained hydrated.

People who were at risk of malnutrition and dehydration had been properly assessed and supported to ensure they had sufficient amounts of food and drink. Records showed food and fluid intake was monitored and recorded for those at risk. However, it was noted that the activities co-ordinators, who were responsible for recording this information, were not always documenting this information immediately after mealtimes. There were some gaps in the recorded information where it could not be established what people had eaten at mealtimes. This was brought to the attention of the deputy manager at the time to ensure that no future information was lost.

The provider had been taking part in a 'Drinking Project' as a way of preventing people from suffering with urinary tract infections (UTI). Older people are more vulnerable to UTIs which can cause discomfort and lead to a course of medication to resolve. The provider had been actively encouraging people to drink their daily allowance of fluids, 1600ml by 3pm each day. The home had large containers of squash in every room and care staff were encouraging people to drink whenever they passed by. As a result nobody who had been identified as being prone to UTI had suffered one since November 2014.

Health care professionals were involved in people's care when needed. The registered manager was proactive in engaging with healthcare professionals to support people and ensure their medical and health needs were being met. The visitors book showed regular visits from the community nurse, dental hygienist and chiropodist. The local GP attended the home weekly in order to conduct assessments and address concerns. In conjunction with the GP the home was undertaking a blood pressure medication review for everyone in the home to ensure their medicine was still required. One person told us that if they required the doctor at any other times outside of these weekly visits care staff were very quick to organise a visit. Relatives were also kept updated when their family member's health needs had changed allowing them involvement in identifying the best healthcare treatment plan.

Is the service caring?

Our findings

People and their relatives were positive and complimentary about the registered manager and staff. Comments included, "the staff are pleasant, helpful and caring" and "not a bad thing to say about anybody". A relative told us that the care staff had a, "very caring nature" and demonstrated this by saying, "they hug her and show affection, they treat her as their own mum".

Care staff were knowledgeable about people's personal histories and preferences, and were able to tell us about people's interests and hobbies. One member of care staff told us about someone they had supported who was a spinster but very devoted to their brother's family. Another was able to describe a person's specific musical tastes and what tasks they liked to be involved in within the home. Care staff took time speaking with people as they moved around the home. People responded positively and were happy to talk with them. A member of care staff identified that a person was rubbing their head where their glasses had been rubbing. The member of care staff said that she would take care of it to which the person replied, "as if you don't have enough to do". They then applied plasters to the arms of the glasses to minimise the person's discomfort.

People were treated with compassion and kindness when upset. During lunch time a person who had a recent bereavement became distressed. A member of care staff noted that this person was upset and in company with the registered manager sat with her. Both care staff and registered manager spent time trying to comfort the person as they were both aware of the person's loss. The person asked why they were helping them to which the member of care staff responded, "my concern is for you, is there anything I can do". A quality assurance questionnaire for relatives was viewed and positive comments were noted such as, "your staff are always kind and sympathetic when I have been upset after a difficult visit" and "staff attitude is always good in near impossible and exhausting situations".

People were treated as individuals and encouraged to make choices about their care. This included how they wanted to spend their day, where they would like to sit to rest and eat as well as their choice of food. People were also able to choose what time they wanted to get up and go to bed in the evening.

During the inspection a number of people were seen walking within the grounds of the home and were encouraged to do so. People were able to move freely around the home and grounds and could do as they pleased without any undue restrictions being placed upon them. Staff were aware of people's movements around the home.

People were actively encouraged to make their room personal and were able to decorate their room with pictures and personal items. One person showed us their personal effects and said that they, "were very happy here" as they had reminders of their husband who had passed away. People said they were happy living at the home and were satisfied with the care they received.

People were treated with respect and had their privacy maintained at all times. People told us and we observed that care staff knocked on people's door and asked permission before entering. We heard one member of care staff ask, "is it alright to shut this door for a bit of privacy?". When speaking with people care staff spoke in a kind and reassuring manner. Bedroom doors were always closed when personal care was being provided to ensure people's dignity was maintained. When people were living in a shared room there was the ability to divide the rooms into two areas using curtains. This provided people with additional privacy when wanted. Care staff took their time when speaking with people and would approach people smiling making sure they were at eye level to enable clear communication. All the people we spoke with said that they were spoken to politely by the care staff and were called by their preferred name or nicknames. One relative disagreed with the positive comments received and felt that care staff would speak to their relative as if they were a child which they found demeaning. We did not see evidence of this during the inspection. The relative also told us, "the girls are, in the main, very nice".

People's views were requested in terms of how they liked their care to be delivered and any assistance they required. Relatives were positive about their involvement in their preparation and review of the care plans. People appeared well cared for, were dressed appropriately and well-kempt.

The registered manager told us there was a completely open visiting policy at the home. There were no restrictions on visiting times and peoples' relatives and friends could visit when they liked.

Is the service responsive?

Our findings

People we spoke with told us that the care staff took the time to know who they were and addressed them as individuals. People's relatives confirmed that the care staff took the time to understand any interests and encourage them to participate.

People we spoke with told us that they were unaware of the details in their care plans however they were not raising concerns. They told us that their relatives had been the ones involved in writing their care plans. Relatives confirmed that they had been involved in creating the care plans and the updates as required. The registered manager told us that some people were happy to sit and discuss their care plans however others were less interested in doing so. On these occasions the care staff used a conversation sheet so if people mention something significant about a change in their care it was recorded and signed, where possible. Most of the care plans viewed detailed "this is me" information which included personal histories and what was important to them. For one person this included information that they kept forgetting that their husband had passed away and reminded care staff, "please be gentle when you remind me". It continued that they preferred to sleep in their chair rather than their bed which was respected. When we arrived to commence the inspection this person was sleeping comfortably in one of the main lounges.

The home actively sought to engage people in meaningful activities. There were two activities coordinators who were praised by people and their relatives for their work. An activities programme for a typical week was viewed which included singing, flower arranging, outdoor games, poetry, quiz or knitting and film show or discussion groups. There was also access to a computer within the conservatory which people were able to email and Skype friends or relatives. People told us they enjoyed walking and this was also accommodated although some felt they were physically able to enjoy longer walks. There were also external trips available which included trips out to the theatre and trips to places of interest. During the inspection a sing-along was viewed where the registered manager was encouraging people to sing, dance and wear Easter bonnets, lots of people had chosen to participate.

The activities coordinators and the range of activities received very positive comments. One relative said her father had been encouraged to "join the choir" as he had always been a keen singer. One of the activities started a quiz in the sun room during the course of the inspection, originally nine residents had joined to complete but more people joined when they heard it was in progress. It was clearly enjoyed by the people who joined in. The activity coordinator we spoke with was able to show a detailed personal knowledge of people including their likes and dislikes.

People's individual needs were regularly reviewed and plans provided accurate information for care staff to follow. Records showed people's changing needs were promptly identified and kept under review. For example, one person's care plan and risk assessment was continually reviewed and updated after they had become increasingly prone to wandering out of the gates to the location. This had resulted in regular risk assessment had resulted in DoLS application being completed to ensure that their need for independence was maintained whilst keeping them safe. This application had been completed however hadn't been signed which was brought to the registered managers attention. This was going to be addressed before the application was submitted. Concerns regarding this person's ability to leave the location had also been identified during 'family meetings' which involved relatives and people living at the home. In June 2014 it was raised by family members that they had concerns regarding the car park and residents being able to wander around freely with cars coming and going. The provider responded and took action by installing a buzzer system and signage on the main gates to the location. People would have to be observed entering and exiting the location once they had pressed the buzzer. This meant that people who were prone to wandering could do so safely within the grounds of the location and there was a minimised risk of harm occurring as a result.

Care staff told us they reviewed care plans on a regular basis and people, relatives told us they had opportunities to express their views about the person's care and support. Records viewed confirmed this. One relative told us, 'we sat down with the registered manager and wrote it". Only one relative we spoke with felt they were not involved in the process of regular reviews their mother.

There was a clear complaints procedure in place which people and their family were aware of. The registered manager kept a complaints folder however there had been

Is the service responsive?

no formal complaints submitted since the last inspection. Most people we spoke with could not recall having the need to raise a formal complaint but everyone was confident that they could do so with the registered manager should the need arise. One relative said that they had raised minor issues but they were always resolved before it became a complaint. Another relative told us of an issue regarding toiletries being removed from their mothers room and found in other locations which they felt had not been addressed to their satisfaction. However, they were happy to raise with the registered manager as they felt they were listened to and no formal complaint had been made as a result.

Quality assurance questionnaires for November 2014 were viewed where people were asked if they felt that their complaint was listened to and appropriate action taken. 13 people responded and most people responded positively saying they did with comments including, “yes” and “absolutely”.

There was a letter of thanks book in the hall which included lots of letters thanking staff for their kindness, care and support for their family members whilst living at the home.

Is the service well-led?

Our findings

The registered manager was visible to people and easily recognised. All people we spoke with were able to identify the registered manager by name. Conversations between people and the registered manager was personal and informal. One person told us, “the registered manager is responsive – no complaints”. The registered manager was also visible to people visiting the service, one relative told us, "the registered manager could not have done more”.

The registered manager was singled out for specific praise by relatives. One couple said that when their relative was no longer financially able to meet their payments the registered manager was “brilliant”. They had helped identify various funding sources which the relatives were able to approach. The registered manager reviewed which rooms were available within the revised budget. The relatives told us that the registered manager was “incredibly supportive and honest with them about the costs”.

All staff had been encouraged to provide feedback to management regarding aspects of their role through the use of regular meetings. During these meetings care staff had been asked to identify what they felt was working well within the home as well as what needs they had to support them in their role.

People and their relatives were encouraged to provide feedback regarding the quality of the service being provided through different means. The registered manager used quality assurance questionnaires as a way of encouraging communication and obtaining people’s views on the quality of the service being provided. People told us there were regular resident and relative meetings which were called ‘family meetings’. They also told us they could approach the registered manager at any time. One person told us, “I can always talk to the registered manager.” Another said “the manager always has time for you, her door is always open”.

Minutes from the last two family meetings showed people were actively encouraged to provide feedback on what they felt was working well. They were also encouraged to let the registered manager know where improvements could be made. The results of these meetings were used to support reflective practices in staff and team leader meetings to ensure continuing improvement. Relatives told us that communications between them and the home were good and that the registered manager kept them informed when changes to care had been identified or requested. One person told us “ I can always talk to the registered manager”. Another relative told us that the registered manager “she listens to you, and looks at you and things are done”.

The provider ensured that people maintained their links with the local community. On the last Friday of each month the local catholic church would attend to provide communion for people who wished to take part. The home also had links with a local school and invited people to see some of their school productions. The school also provided their school bus in order to collect those who wished to attend. One person told us they grew up in the local area and knew it well so the links to local community were particularly important to them.

The registered manager provided a strong presence and support system for care staff. One member of staff told us, “she is really supportive, I’ve got a few personal problems and she’s been great, really supportive…. it’s why I’ve been here so long…she’s fantastic, if she can do anything for you, she will”. They continued, “it makes a big difference when you’ve got a strong manager or someone you can lean on and I think that’s why a lot of the girls stay here because if she can help you, she will”. This view was shared by the relatives we spoke with who said that there was good continuity with the care staff had been at the home for many years. Care workers told us that the registered manager was supportive, “the registered manager’s door is always open to tell her anything you need to” and “yes, I’m supported by the staff and management alike”.

The provider sought to work in partnership with other agencies. We viewed the results of a Care Home and Integrated Care Team link meeting dated on the 10 March 2015. This was a meeting held between with the registered manager, the provider and other healthcare professionals including the community nurse, the intensive care matron and representatives from the South Coast Ambulance Service. These meetings were occurring on a bi monthly basis. During these many areas were discussed including the MCA, infections, falls, discharge/transfer issue and staffing. As a result of discussions actions were identified, raised and completed. For example, it was identified in August that there was a need for staff to have flu vaccines, by October 2014 this had been completed. This was an

Is the service well-led?

example of where the provider was participating with other agencies in order to ensure that there was a link between all services involved in delivering and responding to care concerns and to meet people's needs.